Final Report:

Delivering Dignity through Empowered Leadership

A research study investigating the reasons why some student nurses will report poor practice whilst others do not.

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Executive Summary

Background

Recent scandals in the healthcare environment have led to the image of nursing as a caring profession being distorted. Student nurses were in the clinical areas at the time under investigation in the Francis Report (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) but little was said about them in the report. Whether student nurses should speak about poor care which they see, or whether the expectation that should happen is unrealistic has been mentioned in opinion pieces in the popular nursing press, some of them written by students. This study looked at why some students do speak out and attempted to see if there are some common leadership attributes of those that do.

Literature Review

A search of the literature in relation to research studies in which student or qualified healthcare practitioners raised concerns or 'blew the whistle' identified 14 articles for consideration. These led to a discussion under the following themes.

- The personal impact of whistleblowing on the individual who reports poor practice including the perceived damage to working relationships.
- The reasons behind the decision to blow the whistle.
- The fears and concerns held by qualified health professionals and students that act as barriers to reporting.
- The characteristics of people who do report poor practice.

Aims of the Study

The study had two aims. Firstly to try and ascertain what led student nurses to raise concerns about poor practice which they witnessed and how it could be made easier for them to do so. Secondly to try and ascertain whether there were any differences is the leadership attributes of those who did raise concerns when compared to other student nurses.

Research Methods

Semi-structured interviews were undertaken with 9 service users who were residents in a care home in which students were placed for clinical experience. Semi-structured interviews were also undertaken with five student nurses who had raised concerns with their university. Four of these student nurses completed a Leadership Effectiveness Analysis Questionnaire (Management research Group, 2007) along with eight student nurses who were not known to have raised concerns.

Findings

Both the service users and the student nurses were aware that negative consequences may occur from raising concerns although this featured more strongly amongst the student nurses. The latter did not identify that any of the perceived consequences had actually occurred.

Having an open relationship and a management who were willing to do something was identified as important by the service users. Students also wanted to be supported by the practice placement and the university if they raised concerns. They felt that it was important that they were encouraged to raise concerns.

Although the numbers were too small to show any statistical significance, there was some indication from the leadership effectiveness analysis that reporting students were more likely to be:

- Willing to question the status quo, take changes and are open to change;
- Comfortable with making decisions based on their own values and beliefs, confident and independent thinkers;
- Comfortable with individual interpretation of how tasks should be done, flexible and open to suggestion;
- Trusting in others to follow through on responsibilities, promote trust and empower others;
- At ease in groups, establishing free and easy relationships at work.

than non-reporting students.

Discussion

The points raised by students and service users in the interviews from this study showed the same perceived negative consequences of raising concerns as had been identified in the literature. These included isolation, fear of failing assessments, and being seen as a troublemaker. The issue of support was of major importance to students.

There does not appear to have been any other study which looks at leadership attributes and raising concerns.

Conclusion

The perceived or real consequences of raising concerns continues to be issue for those that are thinking of doing so. There is some evidence that there are different leadership traits for those that raise concerns and those that do not.

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Introduction

The recent reports of the poor care discovered in mid-Staffordshire (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2010, 2013) and Winterbourne View (DH, 2012), amongst others, raise concerns about not just those carrying out the poor standards of care but also those aware that this situation is occurring. However, these types of incidents are the scandals that make the national press and distort the image of nursing as a caring profession. In both the cases named above there were individuals who tried to raise concerns but these were not heeded. People who raise concerns are often said to be 'blowing the whistle'. Jackson et al (2010) suggest that advocacy is a major reason why staff blow the whistle. Vaartio et al (2006) explored the nature of advocacy and determined that advocacy was going beyond good care to protect service users.

Lachman (2008) discusses different levels of whistleblowing and the fact that if the immediate supervisor is causing the problem in an organisation then the whistleblower will have to go to the next level in the management hierarchy. However, if this level is also blind to the dangers that may be occurring within the organisation then the whistleblower's loyalty to the organisation may be questioned. Lachmann (2008) goes on to describe the negative consequences that may occur to those who do blow the whistle. These range from broken promises to fix problems through to whistleblowers losing their job. This type of negative consequence was also raised by Ahern & MacDonald (2002) and Firth-Cozens et al (2003a). Vinten & Gavin (2005) suggest that there are sometimes conflicts between healthcare workers' professional obligations and their employment obligations. However, there are those regularly present in healthcare environments who do not have a contract with an employer but do not appear to regularly raise concerns about practice.

Students in clinical practice were working at the Mid Staffordshire Hospitals Foundation NHS Trust during the time which was investigated by Francis, but their role in reporting did not feature in the Francis report (The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). The Public Interest Disclosure Act (Legislation1998) in the UK encourages and provides protection for employees who raise concerns within their organisation so that investigations of wrongdoing and poor practice can be undertaken in the public interest. The act of reporting concerns is often called 'whistle blowing'. The Public Interest Disclosure Act is supposed to protect those that whistle blow from any negative consequences that might occur as a result of reporting poor practice, and this protection extends to involving regulators if the organisation does not take any action. In spite of these protections, there are still reports of negative consequences suffered by those who raise concerns about poor practice (Firtko & Jackson 2005; Lachman 2008).

Lachman (2008) suggests that whistle blowing on issues of neglect and wrongdoing requires moral courage in the individual reporting. Student nurses may feel more vulnerable than permanent staff within a placement area and therefore it is reasonable to assume that students may need greater moral courage to report concerns. Duffy et al (2012) argue that we may be asking too much of students when it comes to reporting poor practice as they may lack the experience and knowledge to distinguish appropriate and inappropriate departures between the evidence based practice taught at university and the clinical practice witnessed. Daylan (2011) discusses how blowing the whistle dented her confidence and led to her taking time out of her nursing course as a result. Graveson (2008) discusses the guilt she felt as a student nurse who witnessed poor practice and did not report it. This emotion is mirrored by other student nurses in a case study by Levett-Jones and Lathlean (2009) in which students who felt insecure, ostracised, or isolated were more willing to conform and less likely to question practices with which they were uncomfortable.

This project had four elements to it:

- An in-depth review of the literature on raising concerns by students
- Interviews with service users on their expectations of student nurses in relation to raising concerns about practice
- Interviews with students who had raised concerns about practice
- Comparison of leadership attributes of students who raised concerns with those of nursing students who had not.

Literature Review

Search Strategy

The question to be answered was: 'Do student nurses raise concerns about poor practice?'. However, the paucity of literature in this area meant that the search was expanded to include all healthcare students and healthcare practitioners.

Cinahl and Medline were used to search for research into whistleblowing after the year 2000. All non-research papers, systematic reviews and literature reviews were excluded. Where it appeared that more than one article had been published by the same authors in relation to the same piece of research, only one of the articles was included – this occurred on more than one occasion. In addition research where whistle blowing or raising concerns was not the central topic of the paper, even if it had been mentioned at some point within the research article, was discarded. At the end of this process fourteen articles were identified. These can be seen in Table One.

The Literature

A number of themes emerged from the literature review. Each of these will be explored further.

- The personal impact of whistleblowing on the individual who reports poor practice including the perceived damage to working relationships.
- The reasons behind the decision to blow the whistle.
- The fears and concerns held by qualified health professionals and students that act as barriers to reporting.
- The characteristics of people who do report poor practice.

Impact of Whistle blowing on the individual who reports poor care

Peters et al (2011) used a narrative enquiry method to explore the experience of whistle blowers, and their reasons for whistle blowing. The participants experienced whistle-blowing as highly stressful, at times feeling stigmatized and overwhelmed. The study also found that these effects can persist for an extended period of time, and that significant levels of distress in whistle-blowers are not always evident. The authors acknowledge a limitation to the study in that volunteer bias may have resulted in attracting people who have yet to reach closure on their experience rather than those who have come to terms and moved on.

Firth-Cozens et al (2003a) used an anonymous questionnaire to sample the attitudes to and experiences of staff reporting poor practice. Their study found that a small number of professionals (doctors and nurses) report negative repercussions such as stress and victimisation by others, the majority reported no negative effect of whistleblowing, stating they would do the same if the situation were to arise again.

The beliefs of those who blow the whistle

Several studies have set out to explore the reasons why individuals choose to blow the whistle. Ahern and McDonald (2002) undertook a large scale survey of nurses in Australia using an instrument that asked participants to rate their agreement with statements drawn from code of conduct documents relating to patient advocacy, and other statements reflecting the traditional beliefs such as nurses being required to follow doctor's orders. Their findings indicated that those participants that identified themselves as having reported misconduct also supported the beliefs inherent in patient advocacy. A smaller study by Jackson et al (2010) involved in depth semi structured interviews with nurse whistle blowers arrived at much the same conclusion that the participants believed that they were acting in accordance with a duty of care.

Mansbach and Bachner (2010) asked nurses to assess the severity of wrongdoing within 2 scenarios; one describing a colleague who falsified documents to get a job, and the other involving a manager intending to redirect funding away from patient benefit. Both vignettes were seen as serious misconduct by the participants. Interestingly, nurses reported being more willing to raise concern about the manager's actions than the colleague's actions. In both scenarios, the respondents reported that they would be more likely to report the misconduct to someone inside the organisation rather than an external body.

King (2001) sought to examine if differences in perceptions of the nature and severity of wrongdoing could affect the reporting of the wrongdoing. Using a survey design with 372 respondents, eight scenarios were devised, and respondents asked to comment on the severity of wrongdoing, and whether or not it should be reported. Four of the scenarios described unintended wrongdoing, (nurse touches patient without consent, leaves side rails down and patient falls) whilst four described intentional wrongdoing (narcotic abuse by a nurse, nurse threatens a patient). As in the study by Mansbach and Bachner (2010), the perceived severity of the wrongdoing had a significant role in whether participants believed that an incident should be reported. However, where the wrongdoing was seen as unintended, the respondents indicated that they would not report the incident. Instead, they would speak to the person involved to seek an explanation and to give them a chance to report the wrongdoing themselves.

Beckstead (2005) also sought to understand how nurses make decisions about whether to report a colleague for wrongdoing. Consistent with the study of Mansbach and Bachner (2010) they also found that intentionality played a significant role in the decision to report. However Beckstead's study also integrated information on the mental health of, and substance use by the person involved in wrongdoing. They found that nurses combined different types of information in complex ways, weighing up the importance of each factor in the light of other factors. Overall, the findings suggest that nurses may be using critical thinking skills not unlike those used to make inferences about the state of the patient and to decide a course of action.

<u>Factors that affect the decision to raise concerns</u>

Despite the introduction of legislative protection for whistle blowers, and improvements in organisational reporting systems intended to protect health care professionals who report poor practice, a study by Attree (2006) suggests that concerns remain. Attree (2006) conducted semi-structured interviews with 142 practicing nurses across three large employers in the UK. The results identified two broad factors as disincentives for reporting; the fear of negative consequences and lack of confidence in the organisational reporting system. Fear of repercussions,

retribution from others, labelling of the whistle blower and blame for raising concern about which nothing would be done were commonly expressed. Moore and McAuliffe (2009) similarly identified the same findings from a large scale study in Ireland. Both studies identify the need for urgent reform of the reporting systems, to ensure that action is taken on concerns, and that all those who report poor practice are treated with consistency and equality.

Firth-Cozens et al (2003a) also identified participants who considered reporting poor care, but did not go ahead. The reasons for not reporting included personal factors such as fear of retribution and not wishing to cause trouble, and perhaps more concerning, that participants believed that they would not have been listened to. Student nurses and midwives also express concerns about reporting poor care in a study by Ward (2010), who undertook semi-structured interviews with 40 nursing and midwifery students to study their experience in relation to compliance with infection control precautions observed in clinical practice. That study found that students were reluctant to report poor practice for fear of failing placement and the fear of being judged negatively by staff. A smaller study by Bellafontaine (2009) also found that students were reluctant to report poor care for fear of failing placement, jeopardising the student- mentor relationship, and fears of not being supported by the placement or the university. Interestingly, students also reported that they sometimes lacked the experience to judge whether what they had witnessed, actually represented poor practice, and therefore kept quiet.

Mansbach, Ziedenberg and Bachner (2013) replicated their earlier study (Mansbach and Bachner 2010) examining the likelihood of reporting colleague wrongdoing amongst nurses, this time with student nurses. The same scenarios involving colleague wrongdoing and managerial misconduct were presented to the students. The findings indicate that the students considered that the wrongdoing was serious in both scenarios, and stated that they would take action. As in the study on nurses, the students were more likely to report wrongdoing to someone in the organisation rather than externally. It is not clear from the research what mechanisms are in place for the student to report concerns through their educational facility, and whether they would see that as ‘external reporting.’

Characteristics of Whistle Blowers

The final theme emerging from the papers reviewed is research aimed at the exploration of the characteristics of the whistle blower. Moore and McAuliffe (2010) found that nurse managers were more likely to report poor care than staff nurses. Mansbach, Melzer and Bachner (2011) also found that qualified physiotherapists reported that they were more willing to intervene internally, whilst students were more willing to report externally. Beckstead’s 2005 study involved students and qualified nurses, though there was unfortunately no analysis of their data to address the differences between students and staff nurses in their responses. These studies

are suggestive however, that there may be a difference in reporting based on role, with those who are qualified having greater confidence, or perhaps greater commitment to reporting wrongdoing.

Zwart et al (2011) studied Dutch general practice trainees with the aim of exploring the number and nature of incidents reported and to determine whether there is a difference between reporters and non-reporters based on their performance evaluations. Interestingly, the study found a positive relationship between incident reporting and evaluation of competence on the subscale item ‘clinical expertise’ of the CanMEDS evaluation form. This suggests that for these trainees, clinical expertise is associated with reporting a greater number of incidents.

Aims of the Study

The study had two aims. Firstly to try and ascertain what led student nurses to raise concerns about poor practice which they witnessed and how it could be made easier for them to do so. Secondly to try and ascertain whether there were any difference is the leadership attributes of those who did raise concerns when compared to other student nurses.

Research Methods

This was intended to be a mixed methods study. The first part was to be qualitative exploratory study. Qualitative research is used to give rich description where there is little known about a subject (Allsopp, 2013). Participants were service users from a local nursing home who had agreed to participate in the study and students from a local university who had raised concerns about the practice they had seen whilst on placement. The service user participants were interviewed at the nursing home using a semi-structured approach. This approach was used because it allowed a list of topics to be covered whilst allowing additional questions to be asked or the order to be changed (Gray, 2014). The study went through a university ethical approval process. It was recognised that the service user participants could be seen as potentially vulnerable people. However, it is also important to ensure that this group of people are not excluded from research simply because they are vulnerable. Service users who are residents in care homes may be on the receiving end of poor care if perpetrators are aware that they are not visited regularly and this was the reason the opinions of this group were sought. This was not the case with the residents participating in this study. However, the voluntary nature of their participation was underlined. The participants were recruited by the education lead from the home who was not directly involved with the care of the residents. Any confused residents were not approached. When working with the service user the questions did have to be varied to include the raising of complaints about care in a more general way as the service users did not always comprehend the hypothetical nature of the questions relating to student nurses and were more comfortable about talking about the raising of concerns more generally. The interviews took place at the care home in a place of the residents choosing. They often chose their own room. The interviews were tape recorded.

The students who had raised concerns with the university and whose concerns had been forwarded to the appropriate member of senior staff were approached by email once any interventions required by the concerns they raised had been completed. As this means of contact was fairly unsuccessful, programme leaders were asked to directly hand out participant information to those who had raised concerns. Unfortunately, for some students this coincided with a period of time when they were away from the university prior to qualification so some students were lost at this point.

It should be noted that other students may have raised concerns with either their placement or personal tutors but these were dealt with and did not come to the attention of a senior member of staff. It was where these concerns were unresolved that they were directed higher up the hierarchy for a formal approach to be made to the organisation involved.

A similar semi-structured approach was taken to the interviews which were held in the office of the interviewer. Where a member of the research team had been directly involved in dealing with the concern raised by students they did not undertake the interview. Once again the interviews were recorded.

From the transcriptions, common themes were identified independently by two researchers on the project. This is close to the expert validation described by Parahoo (2006). However, unlike the process suggested by Parahoo (2006), both the researchers were involved in the project thus eliminating criticism that the ‘experts’ knew nothing about the research. However, the use of two people to identify themes enhanced the rigour of the research.

Leadership Effectiveness Analysis

The Leadership Effectiveness Analysis™ (LEA) is a reliable, validated self-assessment tool developed by Management Research Group® (MRG) from a seminal study of the perceptions and responses used by effective leaders. Based on the original study and subsequent research, MRG and have developed a unique leadership model. The model is based on the identification of ‘leadership sets’ to describe the framework that people apply in leadership activities. A ‘set’ is a tendency to view situations from a particular perspective and to respond to the situation in a consistent way. For example, faced with a new problem, one person may respond by looking to the past for precedents, whereas another may look for a new solution. The value of a leadership set is dependent on how effective that perception and response are in achieving the desired results (Management Research Group, 2007). A leader in charge of a high pressure sales team may have a ‘leadership set’ (perspective and response) that promotes competition and individual performance to achieve sales targets, a ‘leadership set’ that is unlikely to be effective in developing collaborative partnerships between health and social care professionals. The LEA model therefore recognises that leadership effectiveness depends on the leadership sets used, and also recognises that these sets can be developed to improve effectiveness in different situations.

The use of LEA in this project was undertaken to compare the ‘leadership sets’ of students who report poor practice with students who do not. Students were recruited into 2 groups; the group of reporting students were those students who were interviewed because they had raised concerns, the group of non-reporting students were recruited by volunteering for the study in response to an email invitation sent to the student population as a whole.

All students completed the online LEA questionnaire consisting of 66 items. The tool is structured as a forced choice questionnaire meaning that a response to each item is required. The tool tests each of the 22 leadership sets a total of 11 times using a sophisticated algorithm militating against participants manipulating responses to achieve a desired outcome. The resulting profile generates a score that fits into a range of 5 frequencies; low, low-mid, mid-range, high-mid and high based on the frequency of choice of the set across the range of items offered. A low score indicates infrequent choice of the set, a mid-range score indicates that the participant chose a particular set some times preferring a different response at other times faced with a similar situation, and a high score indicates the set was chosen consistently each time it was presented as an option.

Owing to the small sample size, detailed statistical comparison between groups was not possible. The profiles were therefore analysed using visual comparison by a member of staff trained and licensed by MRG in the interpretation of the profiles. Each student will receive individual feedback on their leadership profile from a trained and experienced facilitator licensed by MRG.

Data

Over the period of the study 12 students were identified who had raised concerns with the university that had been directed to a senior member of staff. Of these 5 students agreed to participate in the study but only 4 completed the LEA questionnaire. 8 non-reporting students were recruited to complete the LEA questionnaire.

9 service users from the care home agreed to be interviewed.

Analysis

Service users
Two themes emerged each with several categories identified:

> **Speaking out**
> Consternation
> Characteristics
> Courage
> Consequences
>
> **Management**
> Managers
> Atmosphere
> Training

<u>Speaking out</u>

A small number of service users expressed concern at the fact that care of older people was not always of a standard that they would expect;

> *"It shouldn't happen. Especially when a person gets older. They're more sensitive. And they need more care!"*
>
> *"People should imagine it was their mum or dad."*

It is clear that they could not understand why people would become carers if they felt able to treat service users badly. However, most service users recognised that it was hard for students, who were transient members of staff, to speak up when they saw something they thought was not quite right;

> *"And it must be terribly difficult coming into a new place."*
>
> *"The thought might be 'I daren't rock the boat', even if it is a reasonably free atmosphere, because that depends I think on the courage and nature of the student,"*

There was even some suggestion that a service user understood that permanent staff would be unwilling to raise concerns in certain circumstances;

> *"…. obviously the regime must have been so strict that they were afraid they would get the sack."*

In addition there was a realisation that service users themselves might find it difficult to make complaints;

> *"I think number one if they're old, and they're afraid of being moved about from place to place, and they……….you're more or less……… you're stationery, "oh I'm alright here leave me alone." And they don't want any change, I think older people, from my opinion, is that they don't like change. You get used to a certain thing………er………and if you're quite content like that – I mean, I'm used to this place, after all these years, and I'm content."*

There is some suggestion here that it wasn't the cause of a potential complaint that was as frightening as the fact that the service user might end up without a home and being moved onto somewhere else that wasn't familiar and that they would have to start all over again getting used to the rules.

The personal characteristics of students were also mentioned;

> *"You see they're shy, student nurses. They're young girls, probably, and they're shy and they don't want to complain."*

Service users were very well aware of potential negative consequences of complaints. As well as the fear by staff of being sacked and the fear of service users that they may lose their homes mentioned above, there was reference to students getting a poor report and victimisation in the form of staff making life hard for anybody who made a complaint or the person complained too being sharp with the complainer and ignoring the complaint.

Service users felt that if they had a complaint that wasn't dealt with by the staff where they were – and generally it was felt that their complaint would be – they would be able to get their family to deal with it. There was recognition that even in the dementia unit, where the majority of service users were confused, there were a lot of visitors who would be likely to raise concerns if something was wrong. The implication was that where there are not a lot of external people around then staff who were that way inclined could get away with carrying out care that was substandard;

> *"If everything is open………if anybody tried bullying, for example, and a visitor was walking past, or one of the nurses or the staff it would soon be found out here. That is my opinion because walking around the place you can see how open it is."*

> *"I think it's the nature of the person …..who takes the job. You can't be in a dream to take a job….. working here. It takes a certain sort of*

person, and some of the people……. who are just there have got the chance – an opportunity to bully somebody – and that's what they do."

Management

The service users were clear that they would expect complaints to be directed towards the manager of the unit;

> *"I think if one person went to see the management, and spoke about something they don't like – well what they would do about it I don't know – in here they would do something about it."*

> *"Report it. Initially the nurse in charge on the floor."*

> *"Well I'd expect them to report it! In fact if I'd had to see it I would report it to xxxxx who – she's very very good she's in charge of all the carers here and everything."*

The important thing that service users recognised was that if something was reported that action would come out of it. The service user who mentioned that something would be done about a complaint was not the only one who suggested that that would be the case;

> *"She's very positive, she's very, very good. Y'know, she'd try and investigate it."*

One service user commented on the fact that students were more likely to raise concerns if they felt they would be listened to;

> *"But it depends on how that person kind of………… presents things. And accepts things too. Well certainly if the student thinks they would be heard, and it would be acted upon, which does not always happen."*

The atmosphere was felt to be very important. In relation to this the service users often expressed their present experiences of being cared for but the majority expressed the importance of the environment;

> *"[Atmosphere] I think that is very important. And I think a student probably feels that too. When they have been a week or two in a place they, kind of, will feel, whether they could make a comment or would rather not."*

“I think it’s the attitude of the carers……….the nurses………..and those in charge….. are very good.”

There were also comments made on staff knowing what was expected on them and also the setting of standards;

“That’s what should be done, they should be made welcome and should be informed about they’re entitled to do…….. and not do.”

“I think it’s the directors of this place. [So they set the standards do they?] Yes, yes, yes. [and if the standards are less they intervene and...] It’s never any less, because they’re used to perfection and they get it.”

Overall, service users found the abuse of elderly people upsetting but had some understanding about why student nurses might not complain and there was a suggestion that this was understandable. It was felt that this is prevented by having an open atmosphere where complaints would be listened too and bad practice would be visible because of the likelihood of external visitors to the organisation being present.

Students

There were three themes with ten sub-themes identified:

The situation

- The problem
- Timing
- Challenge
- Relationship to Reportee

Support

- Attitude
- Placement Support
- University Support
- Role confusion
- Policy
- Actions to Help

Effects

- Reporting Consequences
- Outcomes

The Situation

Four of the students interviewed identified what it was that made them report the incident. For two of them it was the attitude of the person they were complaining about. For one of the two it was the way the person spoke about patients they were caring for and for the other it was the way they spoke to their patients. One of these nurses also stated that in addition to the attitude of the person they complained about there were poor procedures carried out. The student felt a bit conflicted about the person they were complaining about who was newly qualified;

> *"I would have expected somebody that had qualified so soon would….have a gold kind of standard of practice, that you'd look at them and think oh you know 'that's the right way to do it'." (R3)*

> *"I didn't want to seem like I was being really picky about things because this nurse was newly qualified as well and I guess you might look at it as in ….they haven't had much time practising." (R3)*

The other students talked about standards. One felt that what they saw put the patient's safety at risk. The other one talked about it going against what they taught and believed;

> *"I think obviously erm when you attend Uni to do your nursing, it's almost ingrained into you what is good care and what's bad care and for me this that I saw went against everything that we've sort of been taught. But not only that, sort of on a personal level, you sort of have values of your own, and it just went against what I believe to be a good standard of care." (R5)*

The student above felt that things did happen in practice that they would probably not report because they were able to talk to the person about why it happened and what could be done to prevent it in the future but they felt that what they had witnessed on this occasion was more than one issue. However, this student was not confident that all students would have spoken up;

> *"That's my personality, to be able to confront somebody and discuss something with somebody." (R5)*

Other students also talked about whether they would report all incidents they saw. Four students discussed the fact that there may be occasions where there may be doubt about whether to report poor practice. Confidence was expressed as an issue;

> *"…This was in the first year for me so I was new to the environment. I'm a bit wiser now and I probably would have the confidence to report to a senior person." (R1)*

The relationship with practice was another reason given particularly when couple with student inexperience;

> *"…if you had a placement where the team wasn't as nice anyway and the you were to something it's as if you're going above them and you're just a student, really, if you know what I mean, like, you're kind of telling them how to do their job and that they're wrong, and well you're only a student so what do you know?, if that makes sense." (R2)*

Other students talked about differentiating with other poor practice they'd seen but not reported;

> *"I've known a lot of people that have witnessed, like, poor practice and there's times I've witnessed poor practice but not really reported it because it's maybe been, like a one-off occasion like the rest of the time the person's quite good at what they're doing and things but yeah it is difficult because I know everyone works in a different way and as a student you kind of question yourself more, so you think it's me not really understanding." (R4)*

Challenge was incorporated into the responses of two students. One student actually challenged the person she complained about;

> *"So I questioned her 'should we be doing that?' and continued, despite my challenges." (R1)*

The other student who mentioned challenge was asked to challenge the person they complained about after they had made the complaint. It felt to that student that they were being asked to deal with the situation rather than it being investigated.

When raised concerns, it was recognised by two of the students that it was much easier to raise concerns once they had got to the end of their placement so they gave the information when they were leaving and would not experience any negative outcomes. Another student thought about the behaviour of the person they were

complaining about for quite a while before they raised their concerns hoping that things would be better on their next shift. However, after they had seen similar behaviour on three different shifts they felt they had to raise their concerns to somebody.

One student felt that it was important to have a personal relationship with the person they reported their concerns to;

> *"…..still been quite nervous to approach somebody that might not necessarily have spoken to me before." (R1)*

That student reported the incident to the charge nurse in the clinical area but felt that he wasn't taking the incident as seriously as the student felt it warranted. They then contacted their personal tutor who also happened to be the liaison lecturer for the area where the concerning incidents occurred. However, the student made it clear that it was because the person was her personal tutor that she raised the incident and not in their role as liaison lecturer which just happened to be a coincidence.

Another student tried to report her concerns to the liaison lecturer but received an out of office reply on her email so instead went to the Practice Placement Unit who are the administrative who notify students about where their placement is going to be located. This student felt that they would speak to the clinical area where they saw a concern if they felt it was ' a one off occurrence' which would be dealt with. However, if it was more severe and they had spoken to the manager in the clinical area they would come to the university. The student felt that it was easier to talk to somebody at the university.

One student who raised a concern had done so with the clinical area. In this case other members of the clinical team had also witnessed a similar occurrence so the student was encouraged to make a statement about what she had seen along with other members of the team.

The student who did independently raise concerns with the clinical lead of her area did so after speaking to a friend who spoke to their mentor about the incident. The student who had concerns then spoke to that mentor as well to get reassurance that they were doing the right thing. They then reported this to the clinical lead for the area but, as was mentioned earlier they were asked to confront the person who they had concerns about themselves which she felt was the wrong thing for her to have to do. The student finally raised their concerns with the university.

Support

Three of the students felt that their placement areas supported them and two of them felt that they did not;

> *"I thought she might think that I'm making something out of nothing, kind of thing, but she was quite reassuring and supportive and happy to take on what I'd said." (R3)*
>
> *"On that ward lots of things happened so they were very unsupportive of students. They weren't really good with patients, a lot of things seemed to happen. It was sort of a case that 'this is the norm for the ward'." (R5)*

Several of the students talked about the environment that would make them feel supported to raise concerns. One student who did not feel supported felt that she was not treated as part of the team in the way that she had been in other areas. Another who had felt unsupported felt that where it appeared that the management of the area was approachable they would have felt able to raise concerns with them.

One of the students who did feel supported by the clinical area did feel, however, that if she had gone back to the area afterwards that members of the clinical team would have made it obvious that they were not happy that she had raised concerns.

In relation to support from the university, the students also felt that this was mixed. Three students felt that they were really well supported by the university;

> *"We have a cohort meeting every semester and xxxx she'll always discuss things about reporting bad practice which is good." (R3)*

Another student knew that there was potential for the university to support them by actually coming into clinical practice to discuss issues with staff from the clinical area but was unsure about the mechanism by which this should occur. A further student was less effusive about the support that they got from the university;

> *"I know the university is quite supportive but I just felt a little bit let down. I felt that after I'd spoken to my tutor I didn't really get the support I actually wanted and needed. So maybe more support from the university in terms of just giving a bit more advice and a bit more information about what I should and shouldn't do rather than questioning me and putting it all back on me." (R4)*

Two students, although finding the university supportive were a little confused about who to report to;

> *"I think the system is there, it's a bit……where do I go first? Who do I talk to first?" (R3)*

The university does have a written policy about students raising concerns about clinical practice. Although all of the students said that they knew that they should contact somebody at the university they weren't actually aware of the policy;

> *"I don't know if it is a written policy – I've never read it if that the case so maybe – I don't know – maybe that should be advertised a little bit more if there is one, but we're always told about – to go to – to try and talk about it with somebody on the ward if you feel comfortable and then, if not, you know, to talk to you liaison lecturer." (R5)*

In terms of how students could be supported more both the student above and another student felt that students needed to be more aware of the fact that they should speak up about bad practice;

> *"I think we should be encouraged more, I think we should be encouraged to do it more, because I know quite a few people who've, you know complained about, like, their mentors or you know, if they've seen something and they've not actually reported it. I think they should be encouraged to do that more because, you know, then somebody else has got to go on that placement and have the same mentor and nothing's going to have changed." (R2)*

Another student felt that what was needed to encourage students to speak up more was to be made to feel part of the clinical team as they felt that that would improve their confidence to speak up if they had a better relationship with the clinical team.

Effects

Students did consider the consequences for themselves of raising concerns. One student felt that they might be excluded from the clinical team they were placed with. Another student felt that staff members would not want to work with them in case the student was 'picky' over the way the staff practised and also worried that the staff would gossip about them. A third student commented that they did not want conflict with a professional because they would be the one to appear to be in the wrong because they were the student. This student was also worried that it would be taken out on them by the mentor not passing them on their placement. A fourth student felt that people in the area complained about might not like them and might treat them

differently so making life difficult. This last student, however, felt that this was not the important thing to consider;

> *"You've got to have that balance haven't you where you're thinking 'no cos this wrong, I don't really care if they treat me any different cos I need to say something." (R5)*

One student felt that it was not only the staff who might be negative towards them but also other students would treat them differently because once they know that concerns had been raised the other students might get into trouble for not having said something themselves. Another student was worried about consequences for service users in the clinical area

> *"………..the potential that it could affect service users further – not that they were the people that reported it but if I was to report it on their behalf that…it could be taken out on the patient." (R1)*

All of the students accepted that none of the things they were thinking might happen did happen. It was just their perception of what could happen. One of the students was very clear in their view that if a student raised concerns about their placement they should be moved to another placement to avoid any confrontation. This student was aware that other students had been left in their placement after they had raised concerns and the students had felt very awkward about working their afterwards.

When asked what they hoped would happen as a result of them raising concerns two students mentioned that they just wanted something to change. Two students mentioned the importance of them being taken seriously and one student just wanted to know that the clinical area didn't think that they were being too picky about things. One of the students felt that they would like to have been able to go back and ask the people involved why they had done what they had because they felt that those involved knew that what they were doing was wrong.

One of the students did mention that they knew that the situation the raised concerns about was dealt with very quickly and they were involved in further investigations supported by a member of staff from the university and the student found this very helpful. Another student mentioned that they did not know what had happened, if anything, and gave the impression that this was not satisfactory in their opinion.

LEA questionnaires - The Findings

Of the 22 sets contained in each profile, 18 sets were found to have no significant difference between profiles for reporting and non-reporting students. The 18 sets are:

- Innovative
- Technical
- Strategic
- Persuasive
- Excitement
- Restraint
- Tactical
- Communication
- Delegation,
- Feedback
- Management Focus,
- Dominant
- Production
- Cooperation
- Authority
- Empathy.

Of these results, both groups showed the same response patterns for two sets, Persuasion (all scores from both groups below mid-range), and Empathy (all scores above mid-range). The remaining 16 sets identified had scattered distribution across the range with no clustering of responses.

Five sets were found to have differences in response patterns. The Conservative, Structuring and Control set were substantially higher in the non-reporting students than in the reporting students. The Self and Outgoing scores were substantially higher in the reporting students than in the non-reporting students. The data for these sets is displayed in the table in Appendix 2.

Accurate interpretation of the results of these findings depends on the understanding that each set within the model has a specific definition. The labels chosen for the set have common use definitions that are close to, and not the same as the set definition devised by MRG (2007). For example, the word ‘conservative’ is used as a set label, which has a range of common use definitions including membership of a political party or a tendency to be old-fashioned, conventional or orthodox. In terms of the LEA model, conservative is defined as “studying problems in light of past practices to ensure predictability, reinforce the status quo and minimise risk”. A full list of the LEA set definitions is provided in Appendix 3.

Conservative: The Conservative set is defined as 'studying problems in light of past practices to ensure predictability, reinforce the status quo and minimise risk'. Based on their profiles, non-reporting students identify themselves more with this set, being likely to rely on past practices, not being willing to rock the boat. Reporting students as a group are much more mid-range in their responses suggesting more willingness to take chances, challenge the status quo and to be independent of the norm.

Self: The Self set is defined as 'emphasising the importance of making decisions independently, looking to yourself as the prime vehicle for decision making'. Reporting students responses were all in the high-mid to high range whilst 6 of the 8 non-reporting students were mid-range and lower. This suggests that students who have reported poor practice see themselves as independent decision makers, a feature associated with self-confidence in the LEA model.

Structuring: The structuring set is defined as 'adopting a systematic and organised approach, preferring to work in a precise, methodical manner, developing and using guidelines and procedure'. Based on this, non-reporting students present themselves as valuing order, method and consistency more than reporting students. According to the model, lower scores in structuring is likely to be associated with people who respond well to change, are flexible and open to suggestion.

Control: The Control set is defined as 'adopting an approach in which you take nothing for granted, set deadlines for certain actions and are persistent in monitoring the progress of activities to ensure they are completed on schedule'. Reporting students have overall lower scores suggesting that they are more likely to have faith in others ability, allow others to have autonomy and promote trust. Non-reporting students see themselves as highly disciplined, maintaining tight control of the quality and quantity of work, which can appear to others as stifling initiative or perhaps 'micro managing'.

Outgoing: The Outgoing set is defined as 'acting in an extroverted friendly and informal manner, showing a capacity to quickly establish free and easy interpersonal relationships'. Reporting students see themselves as much more outgoing than non-reporting students, with greater social skill, and positive energy in groups. Non-reporting students conversely may be more inclined to work alone, being inner directed, and less likely to easily develop relationships with others at work.
There are therefore some interesting differences between reporting and non-reporting students in how they see themselves in relation to the LEA leadership model.

Overall, non-reporting students see themselves as:

- Reliant on past experiences for guidance, minimising risk and maintaining the status quo

- Value others ideas, influenced by others in the team when making decisions
- Preferring a methodical and systematic approach, using guidelines and procedure, preferring stability
- Highly disciplined, preferring to keep tight control of work tasks
- More reserved, inclined to work alone, and preferring inner direction.

Overall, reporting students see themselves as:

- Willing to question the status quo, take changes and are open to change
- Comfortable with making decisions based on their own values and beliefs, confident and independent thinkers
- Comfortable with individual interpretation of how tasks should be done, flexible and open to suggestion.
- Trusting in others to follow through on responsibilities, promote trust and empower others.
- At ease in groups, establishing free and easy relationships at work.

Discussion

When considering vignettes student nurses were highly willing to report poor practice (Mansbach et al 2013). However, the reality of practice is somewhat different. Similar to the report by Bellafontaine (2009) the students interviewed did not always report their concerns about practice. However, the students in this study differentiated between one of incidents of poor practice which, whilst regrettable, they saw as learning points and ongoing poor practice which they felt would not change unless someone drew attention to it. Vinten and Gavin (2005) suggested that the British character is ambivalent to whistleblowing. Certainly some students suggested that other students had complained to them of poor practice but did not take this any further. Ambivalence does not seem to be the reason, however, why students did or did not complain.

Students and service users mentioned the consequences that may occur if a student made a complaint. The points students raised have been raised by other studies and commentaries on reporting poor care or whistleblowing. Not rocking the boat was mentioned by Ward (2010) and Llevett-Jones & Lathlean (2009). This was also raised as a reason why student nurses might not complain by a service user in the study. Being seen as being picky or not causing trouble was mentioned by Attree (2007) and Firth-Cozens et al (2003a). Being excluded from the team was mentioned by Bellafontaine (2009), Firth-Cozens (2003a) and Jackson et al 2010. Jackson et al (2010) also discussed staff gossiping about the complainer. King (2001) discusses the overt ostracism experienced by whistleblowers which is similar to the students comments about the team might not want to work with them. The fact that the complainer ‘was only a student’ was mentioned by Firth Cozens et al (2003a) and Llevett-Jones (2009) and the concern that students might not pass their assignment was discussed by Bellafontaine (2009) and Ward et al (2010). So the perceptions that the students expressed are not new. However, they were perceptions. Some of the students in the study felt well supported by both their clinical area and their university and even where students were less enthusiastic about the support they received, they did not state that they had personally experienced any negativity. However, some of the studies undertaken with whistleblowers identify that these consequences do happen (Jackson et al 2010).

Other issues raised in Bellafontaine’s (2009) study were also raised in this study. Students wanted to feel that they were believed and felt that where practice relationships were good they would be more likely to report the poor practice. Service users also identified that where the environment was open and that managers were clearly going to take action if something was not right, complaints were more likely to be raised. This is something of a conundrum really because it suggests that those areas where practice is likely to be good because managers listen to complaints of poor practice will make it more likely that students will report.

However, where students do not feel supported or where there is a poor relationship with managers students are less likely to raise their concerns even though it is these environments which are more likely to require concerns to be raised. This ca be exampled by the Kennedy Inquiry into children's heart surgery at the Bristol Royal Infirmary (The Bristol Royal Infirmary Inquiry 2001) where it was stated that the culture there made it difficult for people to speak out. Although student nurses writing in popular journals suggest that student nurses should speak out about poor care (Daylan 2011; Graveson 2008), Duffy et al (2012) suggest that we may be asking too much to rely on students to do so. This is particularly the case when the NHS staff survey of 2014 states that only 68% of staff would feel comfortable raising concerns and only 57% felt confident that those concerns would be addressed (Graham 2015).

The students in this survey did speak out, however, and when compared to students who we are not aware had raised concerns over poor practice there were some definite differences in the leadership effectiveness sets. There does not appear to have been any other research which has looked at leadership style and whistleblowing. Moore & McAuliffe (2009) and Becksted (2004) suggested that it was experience which was a determining factor as to whether people spoke up. However, this does not appear to be supported by this study. Firth-Cozens et al (2003b) has looked at the literature on psychometrics in identifying risky behaviours in those that carry out patient care. i.e. those who are likely to be the cause of concern but there does not appear to be other work on any attributes of those who raise concerns.

The Healthcare Leadership framework (NHS Leadership Academy, 2013) seeks to address some of the leadership failings identified wake of the Francis report. This model states that it is underpinned by personal qualities such as self-awareness, self-knowledge, self-confidence, self-control, resilience and determination. It goes on to state that working to develop these personal qualities can lead to more effective leadership behaviours and that positive personal qualities are embedded in the 9 leadership dimensions that comprise the model. Although these are not exactly the same as the LEA sets there is some congruity with the idea of a confident individual who is prepared to stand up and be counted rather than following the status quo.

Limitations of this study

The main limitation of this study is the small number of student participants particularly in relation to the completion of the LEA questionnaires. Although the differences identified between the reporting students and the non-reporting student appear to be relevant the numbers are too small to undertake any statistical analysis

of significance. The number of formal complaints made to universities about poor care is not high. Therefore, a single university study, in retrospect, is unlikely to provide the data needed to make definite conclusions. However, the lack of participation by invited students was disappointing. They may not have joined in because of the lack of awareness that they had been invited. It is a repeated complaint that students do not read their university emails.

Reporting students were characterised as students who had raised concerns where the concern raised had reached the attention of a senior manager within the university. It is possible that those students who were not characterised as a reporting student had actually raised concerns but that they were dealt with at a lower level or they were resolved immediately within the practice area.

It should be also noted that the service user participants came from one organisation. This was the same for the student nurses who attended the same university. There may be cultural and ethical values that pervade those organisations and mean that the responses given reflect those cultural and ethical perspectives. Although the findings of the interviews given here do reflect other studies from the literature, most of the studies cited, similar to this one, are small scale. However, the differences identified through the Leadership Effectiveness Analysis questionnaire appears to be unique and could reflect organisational specific attributes.

Conclusions

The perceived or real consequences of raising concerns continue to be an issue to those who are thinking of doing so. The environment in which those who raise concerns are working is perceived to make a difference with those places that are friendly, open, accept students as a member of their team and instil the belief that their concerns will be acted upon, being more likely to get students to speak out.

There is some evidence that there are different leadership effectiveness traits of those students who do raise concerns when compared to those that have not. Students who raise concerns appear to be:

- Willing to question the status quo, take changes and are open to change
- Comfortable with making decisions based on their own values and beliefs, confident and independent thinkers
- Comfortable with individual interpretation of how tasks should be done, flexible and open to suggestion.
- Trusting in others to follow through on responsibilities, promote trust and empower others.
- At ease in groups, establishing free and easy relationships at work.

The differences were striking enough to suggest that more investigation around this topic should be undertaken. If it is confirmed that these attributes do enable those who see poor practice to raise concerns then learning activities to develop these in all students should be undertaken.

All students were aware that they could speak out but felt this could be encouraged more. They were not really aware of the existence of a policy about this. This is an area that could be highlighted with students. The policy will be of value to them but the important thing is that they know they are able to speak out and that their voice will be heard.

Recommendations

1) A larger study around leadership effectiveness traits of student nurses who raise concerns needs to be undertaken. This needs to be a regional or national study to ensure the number of participants is large enough to enable statistical analysis.
2) Ongoing work needs to be undertaken with practice placement partners to encourage them to role model an open friendly environment to students that makes them aware that the raising of concerns is welcome
3) The university needs to raise the profile of its policy around raising concerns with students and highlight that the university will give support to students who do raise concerns.
4) Consideration needs to be given to introducing learning activities for student nurses to ensure that those attributes shown by students who raised concerns are fostered in others.

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Appendix 1: Articles included in the review

Authors	Country base of corresponding author	Year of publication	Journal	Method	
Mansbach, A. Ziedenberg, H. Bachner, Y.	Israel	2013	Nurse Education Today	Questionnaire based on 2 vignettes administered to 82 first year student nurses Questions utilise a 1 – 7 rating scale and responses were analysed using a student t-test.	Students considered the conduct identified in both vignettes as serious but would be more likely to blow the whistle internally rather than externally.
Mansbach, A. Melzer, I. Yaaciv, G.	Israel	2012	Physiotherapy	Questionnaire based on 2 vignettes administered to126 undergraduate physiotherapy students and 101 certified physiotherapists. Questions utilise a 5 point Likert rating scale and responses were analysed using a student t-test.	Both groups rated their willingness to take action to change harmful situations highly. Qualified physiotherapists were more likely to take a colleague's misconduct more seriously and more willing to intervene internally. The students were more likely to action externally. Students were more likely to perceive the manager's behaviour as misconduct than qualified physiotherapists.
Peters, K. Luck,	Australia	2011	Journal of	Qualitative interviews with 14	The emotional health of all

L. Hutchinson, M. Wilkes, L. Andrew, S. Jackson, D.			Clinical Nursing	qualified nurses who were either whistleblowers or the subject of whistleblowing episode.	participants was considerably compromised over a long period of time.
Zwart, D. Heddema, W. Vermeulen M. Van Rensent, E. Verheij, T Kalkman, C.	The Netherlands	2011	BMJ Quality and Safety	79 GP trainees were asked to report incidents over a 6 month period. The trainee who reported an incident was interviewed. 3 month competence assessments of reporting trainees and non-reporting trainees were compared. Analysis of quantitative measures was by use of Pearson's X^2 or Fisher's exact tests as appropriate	24 trainees reported 44 incidents with three quarters of the incidents not related to the inexperience of the trainee. Trainees who performed best on their performance analysis were more likely to report than those who performed at a lower level.
Jackson, D. Peters, K. Andrew, S. Edenborough, M. Halcomb, E. Luck, L. Salmonson, Y. Wilkes, L.	Australia	2010	Journal of Advanced Nursing	Qualitative narrative inquiry using semi-structured interviews with 11 nurse whistleblowers.	Comments were put into three categories Reasons for whistleblowing, feeling silenced and climate of fear. Whistleblowing nurses believed they were acting in accordance with a duty of care.
Mansbach, A. and Bachner, G.	Israel	2010	Nursing Ethics	Questionnaire based on 2 vignettes administered to 83 nurses Questions utilised a rating scale of either 1 -7 or 1	Misconduct was viewed as being very serious and nurses wanted to correct the wrongdoing. They were

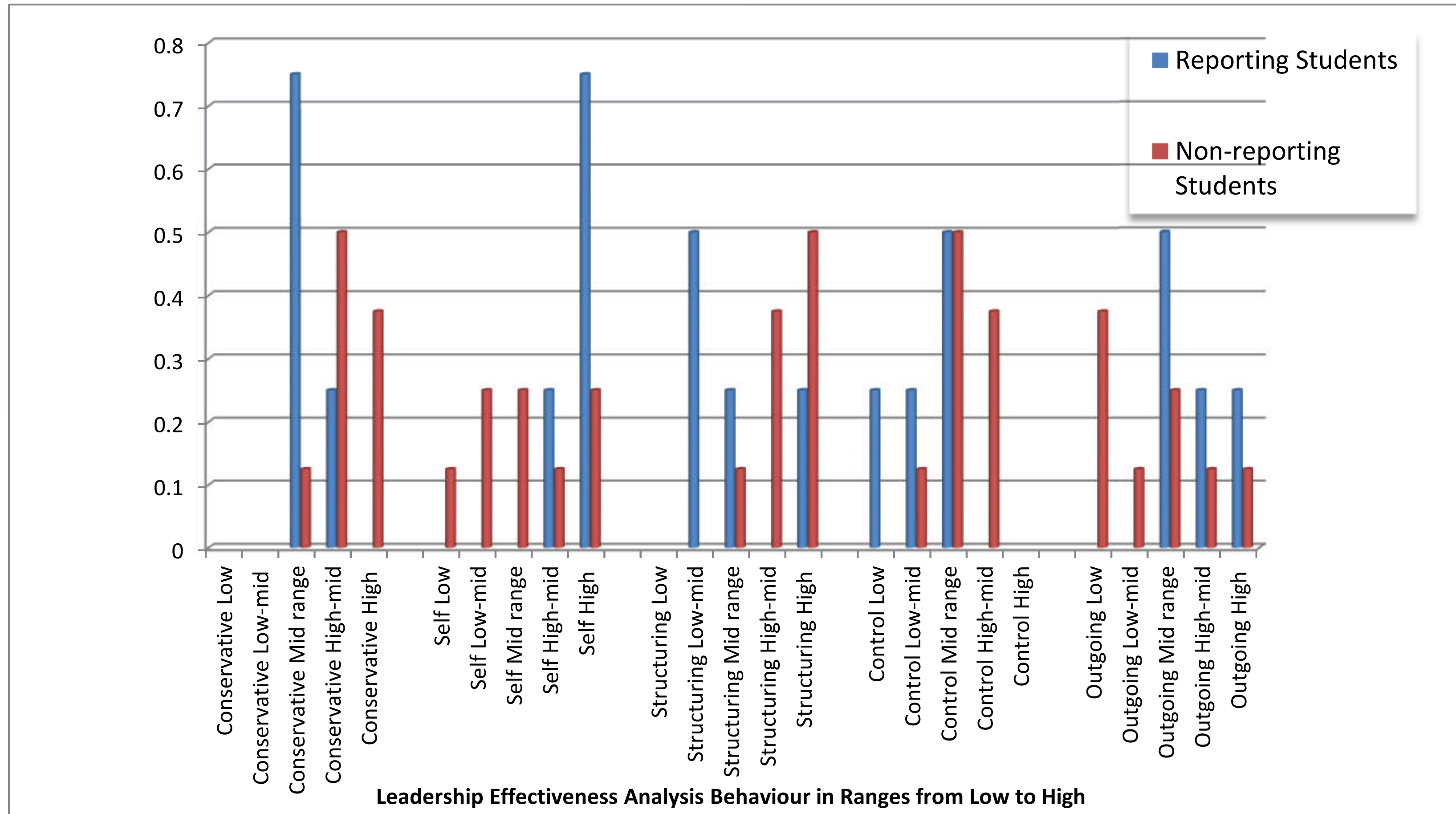
				-4 depending on the question and responses were analysed using a t-test.	more likely to whistle blow internally rather than externally and as the circle of disclosure widened there was a tendency to retract.
Moore, L. McAuliffe, E.	Ireland	2010	Clinical Governance: An International Journal	152 nurses returned questionnaires regarding the reporting of poor practice. The questions were in the form of a Likert scale. The results were not treated inferentially.	70% of those who saw poor practice reported it. Managers were more likely to report than staff nurses. Only 1 in 4 of nurses who reported poor practice was satisfied with the response to it.
Ward, D.	United Kingdom	2010	Journal of Advanced Nursing	Semi-structured interviews were undertaken with 40 nursing and midwifery students.	Students were reluctant to report poor practice for fear of failing assessments and not wanting to be identified negatively by staff. Students believed that theory based practice was important to support any complaints they had.
Bellafontaine, N.	United Kingdom	2009	Nursing Times	Semi-structured interviews with six students using a phenomenological approach.	Role modelling and seeing qualified nurses reporting poor practice was important in encouraging students to report poor practice. The strength of the student-

					mentor relationship was also important.
Attree, M.	United Kingdom	2007	Journal of Nursing Management	Grounded Theory was used to collect and analyse data from 142 practising nurses from three Acute NHS Trusts in England	Reporting poor practice was seen as a high risk, low benefit action. Nurses feared repercussions, retribution, labelling and blame for raising concerns but predicted nothing would be done about them.
Beckstead, J.	United States of America	2005	International Journal of Nursing Studies	120 nurses were given 42 scenarios and were asked to rate the likelihood that they would report the practice within them on 0 – 10 rating scale. Formal Interface Recursive Modelling was used to produce a dendogram showing the likelihood of reporting based on incompetence and/or substance misuse.	Nurses view working under the influence of any type of substance a serious offence but the combining of incompetence and substance abuse cues were complex possibly due to the critical thinking skills acquired during education and practice.
Firth-Cozens, J. Firth, R. Booth, S.	United Kingdom	2003a	Clinical Governance: An International Journal	A questionnaire was distributed to 1000 nurses, 484 hospital consultants and 220 General Practitioners. A mixture of qualitative and quantitative questions about	A quarter of respondents reported poor care whilst another 16% had cause for concern but did not go ahead. Most did not have negative experiences of

				the practitioners' experiences of whistleblowing. Quantitative analysis was undertaking using a t-test.	reporting concerns and would do the same again in similar circumstances.
Ahern, K. McDonald, S.	Australia	2002	Journal of Advanced Nursing	95 nurses returned a questionnaire which had statements relating to whistleblowing and their experience of it. Most responses utilised a Likert Scale	Whistleblowers supported the idea that nurses were primarily responsible to the patient and should protect the patient from unethical and incompetent people. Non-whistleblowers supported the idea that nurses are obligated to follow a physician's order.
King III, G.	United States of America	2001	Journal of Business Ethics	372 respondents completed a questionnaire containing scenario statements of intentional and unintentional wrongdoings	Respondents were less likely to report unintentional wrongdoing but would confront the wrongdoer. Whether a behaviour was reported or not depended upon the severity of the wrongdoing.

Appendix 2:

Leadership Effectiveness Behaviours Showing Differences in Responses on 5 Behavioural Sets



Appendix 3

Leadership Effectiveness Analysis Set Definitions

- **Conservative:** Studying problems in light of past practices to ensure predictability reinforce the status quo and minimise risk.
- **Innovative:** Feeling comfortable in fast-changing environments; being willing to take risks and to consider new and untested approaches.
- **Technical:** Acquiring and maintaining in-depth knowledge in your field or area of focus; using your expertise and specialized knowledge to study issues and draw conclusions.
- **Self:** Emphasizing the importance of making decisions independently; looking to yourself as the prime vehicle for decision-making.
- **Strategic:** Taking a long-range, broad approach to problem solving and decision making through objective analysis, thinking ahead and planning.
- **Persuasive:** Building commitment by convincing others and winning them over to your point of view.
- **Outgoing:** Acting in an extroverted, friendly and informal manner; showing a capacity to quickly establish free and easy interpersonal relationships.
- **Excitement:** Operating with a good deal of energy, intensity and emotional expression; having a capacity for keeping others enthusiastic and involved.
- **Restraint:** Maintaining a low-key, understated and quiet interpersonal demeanour by working to control your emotional expression.
- **Structuring:** Adopting a systematic and organized approach; preferring to work in a precise, methodical manner; developing and utilising guidelines and procedures.
- **Tactical:** Emphasizing the production of immediate results by focusing on short-range, hands-on, practical strategies.
- **Communication:** Stating clearly what you want and expect from others; clearly expressing your thoughts and ideas; maintaining a precise and constant flow of information.
- **Delegation:** Enlisting the talents of others to help meet objectives by giving them important activities and sufficient autonomy to exercise their own judgment.
- **Control:** Adopting an approach in which you take nothing for granted, set deadlines for certain actions and are persistent in monitoring the progress of activities to ensure that they are completed on schedule.
- **Feedback:** Letting others know in a straightforward manner what you think of them, how well they have performed and if they have met your needs and expectations.
- **Management Focus:** Seeking to exert influence by being in positions of authority, taking charge, and leading and directing the efforts of others.

- **Dominant:** Pushing vigorously to achieve results through an approach which is forceful, assertive and competitive.
- **Production:** Adopting a strong orientation toward achievement; holding high expectations for yourself and others; pushing yourself and others to achieve at high levels.
- **Cooperation:** Accommodating the needs and interests of others by being willing to defer performance on your own objectives in order to assist colleagues with theirs.
- **Consensual:** Valuing the ideas and opinions of others and collecting their input as part of your decision-making process.
- **Authority:** Showing loyalty to the organization; respecting the opinions of people in authority and using them as resources for information, direction and decisions.
- **Empathy:** Demonstrating an active concern for people and their needs by forming close and supportive relationships with others.

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