Young people's involvement in simulation with students of children and young people's nursing: an exploratory interpretive study

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Abstract

Over recent years, UK health and social care policy has advocated for the views of children and young people to be sought and acted on to ensure that their voices are considered and that they participate in decisions about their health. However, children and young people are seldom involved in nurse education and when they are their involvement is limited. For example, they are often consulted about issues relating to curriculum development, however, non-tokenistic involvement requires more than this. They need to participate in the planning, delivery and evaluation processes of nurse education. Simulation provides an ideal opportunity for young people to become involved in the teaching and learning of students of children and young people's nursing. That said, the outcome and impact of doing so, for all participants, warranted further investigation.

This thesis provides an analytical account of a qualitative interpretive research study to elicit, discuss and explore young people's involvement in simulation with students of children and young people's nursing. Young people attending a local college were invited to take part in this research study. They worked on the planning of a simulation scenario concerned with the care of a young person (the manikin - 'Elizabeth') presenting to the emergency department with an exacerbation of asthma. Following this they developed a feedback tool and provided 'Elizabeth's' voice during the simulated sessions. Using the tool which they designed, the young people participated in the debriefing to provide feedback to the nursing students about the communication and interpersonal skills used by them during the simulated sessions.

Data was collected from all participants through semi-structured and focus group interviews to explore their perspectives on the impact and outcomes of the young people's involvement. The young people felt valued and listened-to throughout the process. In turn, this enabled them to create a more authentic reality which enhanced the overall simulated learning experience for the student participants. Challenges to young people's involvement are also discussed. The findings add to the current body of knowledge regarding the involvement of young participants in simulation specifically, and the education of students of children's and young people's nursing more generally. Implications for practice, policy and further research are critically determined.

Chapter 1

Introduction

1.1 Background and introduction

This thesis centres upon the involvement of young people in the education of undergraduate students of children's and young people's (CYP) nursing. More specifically, it relates to the participation of young people in the planning, delivery and debriefing of high-fidelity simulation (HFS) within nursing.

I am the lead for simulation in the School of Health and Society and have introduced an innovative approach to the use of simulation in nurse education. Involving young people in the planning and facilitation of HFS is an original concept, and following an extensive review of the literature I could not find any published or unpublished work that reports on this. Over the last ten years in my role as a lecturer in CYP nursing, I have designed, facilitated and evaluated many simulation sessions for nursing students. The aim of this study was to work collaboratively with young people in simulation together with students of children's nursing.

Over recent years, health and social care policy has recognised that the voices of children and young people need to be listened to and that more needs to be done to ensure that they are involved in decisions about their health. At the same time, the increase of HFS within nursing is evident, and local and national policy supports the use of this technology to enhance students' learning.

This chapter begins with a critique of the historical context of public involvement in healthcare and how the involvement of children and young people in healthcare has evolved over the last twenty years. The development of service user involvement in nurse education is then discussed critically. Following this, I address the historical development of simulation and the use of simulation in nurse education.

1.2 The historical development of service user involvement in healthcare: UK political context

No discussion of the involvement of children and young people in healthcare is complete without a detailed discussion of the evolution of service user involvement in healthcare. Since the launch of the UK National Health Service in 1948 service users have become increasingly involved in their own choices and decisions in relation to healthcare. Previously, healthcare provision was dependent on wealth, and those who could afford it would pay for their care. The introduction of the NHS meant that all those living in the UK became entitled to free healthcare financed through taxation, and no longer was wealth a determinant of receiving medical care. Initially, the service allowed individuals to choose their own GP, optician and dentist. Thus, this period represented the foundations of patients being involved in decision-making regarding their own healthcare.

Over the last 20 years there have been substantial developments regarding patient choice and participation in healthcare. The involvement of service users and carers in healthcare has been embedded in healthcare policy since the 1990s (DH 1990, 1991, 1992) and is considered integral to the planning, delivery and evaluation of healthcare services today. As far back as 1996 the English National Board for Nursing (ENB) suggested that the involvement of service users and carers should be integrated into nurse education (ENB, 1996). However, despite the rhetoric, service user involvement in healthcare was still lacking prior to the 21st century.

In 1996 INVOLVE was established, supported and funded by the National Institute for Health Research. The aim of INVOLVE was to actively encourage public involvement in health and social care research, and the organisation is recognised as one of the few government-funded programmes of its kind in the world.

In 2000 the NHS Plan (DH, 2000a) declared that a new modern NHS structure and service would be established, claiming that the then current system was operating within the same structure as when it was launched in 1948. It was suggested that there was a lack of national standards and demarcations between staff and services and that patients were disempowered. The NHS Plan stated that the health service would be designed around the patient (DH, 2000a). It was as a result of this policy that the Patient Advocate Liaison Services (PALS), patient satisfaction surveys and views on local health services were created. Organisational changes within the NHS were further identified (DH, 2001a), advocating that patient voices would be heard,

and the outdated paternalistic model of healthcare would be transformed into a partnership. Patients and the public would be involved in decisions about their care and would be able to influence the design, development and delivery of their local services (DH 2001a, 2001b). Words such as 'engage', 'involve' and 'empower' were associated with the new government plans to ensure that patients' voices would be heard. The Kennedy inquiry into the Bristol Royal Infirmary further supported the view that changes must be made, stating that the perspectives of patients must be incorporated into the planning and delivery of all services at all levels (Kennedy, 2001). In turn, the Expert Patient report (DH, 2001c) recognised that patients were experts in their own conditions and could contribute significantly to reducing the cost of healthcare whilst still improving the quality of care.

Following this, the Commission for Patient and Public Involvement in Health (CPPIH) was established in 2003 as a result of the NHS Reform and Healthcare Professions Act 2002. The CPPIH (an independent departmental public body) was created to set up and support the new patient forums. It was abolished in 2008, and the patient forums were replaced by Local Involvement Networks (LINks). The legislation governing these was the Local Government and Public Involvement in Health Act 2007. Run by local people and groups, LINks had the aim of providing the public with a stronger voice by finding out what people wanted, monitoring local services and using their powers (governed by legislation) to hold these to account (DH, 2010a).

Another government initiative to engage service users was reported in 'Your health, your care, your say' (DH, 2006a). This white paper published the findings from a consultation with the public, which was a comprehensive listening exercise incorporating four events that took place in Gateshead, Leicester, London and Plymouth. The main results of these events were that patients wanted more choice about when, where and how they accessed healthcare services and to be involved in setting local health and social care services. This was then used later that year to produce 'Our health, our care, our say: a new direction for community services' (DH, 2006b). This white paper built on the findings from the public consultations and stated that they would ensure that service users had a strong voice in the way that the whole healthcare system was designed and delivered (DH, 2006a).

Empowerment of patients continued to develop over the next seven years and remains a priority in healthcare policy. The introduction in 2007 of NHS Choices, a web-based tool, aimed to assist patients to make better and more informed choices about their health. In 2007, Lord Darzi's review (Our NHS, Our future) described a vision for the NHS for the next ten years, focusing on more patient control, choice and local service accountability. The review identified that patient choice was largely restricted to elective treatment and that those with long-term conditions should also be awarded the same rights and choices (Darzi, 2007). More specifically, Darzi suggested that service users should be involved in the design of their own care and the support that they require.

Following the recommendation of Darzi (2007), 'The NHS constitution: a consultation on new patients' rights' was published (DH, 2009). Again, patients, staff, the public and key stakeholders were consulted to produce this document. It drew together everything that the NHS stands for, what it does and what it is committed to providing. It was updated in 2013 and specifically states that you (the public) have a right to be involved and included in the decision-making and discussions regarding your care, including family and carers. You (the public) are also entitled to be involved in the commissioning and operational running of healthcare services and to be included in the development of, and proposals to make changes to, current services (DH, 2013).

In relation to healthcare, the most recent legislation passed through parliament is the Health and Social Care Act 2012, which is viewed by some as the most extensive overhaul of the structure of the NHS to date. The Act clearly advocates that patients must have a "greater voice" (DH, 2012a: B3). Fundamental legislative changes are stated, namely, that service providers and commissioners should implement user feedback as a way of monitoring the quality of care and services that they provide. The Mid Staffordshire NHS Foundation Trust public inquiry (Francis, 2013) highlighted that the concerns of staff, patients and carers were continually overlooked and the systems in place to monitor care were not effective or, even worse, were ignored. The Health and Social Care Act 2012 should assist with ensuring that the voices of service users are listened to. The prevention of further incidents and events like those described at Mid Staffordshire is essential. In order

to do this, the NHS was reformed and Healthwatch[1] England was created. The aim of this group is to advise and provide information to the Secretary of State, the NHS Commissioning Board, Monitor, English local authorities and the Care Quality Commission. Local Healthwatch is tasked with championing the voices of patients. It represents the views and experiences of service users and carers. In turn, NHS England pledges to encourage patient and public participation in order to improve patient outcomes and ensure that no one is left behind (NHS England, 2013). It is apparent that over the last thirty years, there have been numerous initiatives which emphasise the importance of empowering people to be involved in decisions about their care, most recently, the NHS Five Year Forward Plan (NHS, 2014) and Long Term Plan (NHS, 2019). Despite such initiatives and increased involvement of service users in healthcare, it is well documented that children and young people still struggle to get their voices heard.

1.3   Involvement of children and young people in healthcare

For many years children and young people have been lower down the list of priorities regarding decision-making in comparison with adults. Kennedy (2010) in his national review of children's services identified that children and young people account for about 40% of a GP's typical workload. Therefore, this group of people make up a significant proportion of the users of healthcare services.

The most significant development underpinning the rights of the child is associated with the publication of the United Nations Convention on the Rights of the Child (UNCRC) (UNICEF, 1989). The Convention affirms that children have a right to be heard and, more specifically, Article 12 states that "Every child has the right to say what they think in all matters affecting them, and to have their views taken seriously". This is further supported by the Children Act 1989, Section 53 (Children Act, 1989, 2004), which asserts that the wishes and feelings of the child must be ascertained and that they must be given due consideration with respect to their age and understanding.

Moreover, the framework for the assessment of need (DH, 2000b) outlines the importance of engaging with children. It highlights the importance of developing a

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[1] http://www.healthwatch.co.uk/

rapport with children that enables them to voice their thoughts, opinions and concerns, which, in turn, facilitates decision-making that is appropriate for their age and development. However, three years later the Laming inquiry (DH, 2003) highlighted that children's voices were not being heard. In particular, communication by social workers with Victoria Climbié was minimal and confined to questions such as "Hello, how are you?". In this report it was identified that a lack of engagement and communication with children was an extensive issue. In response to the Laming report, Every Child Matters (Department for Education, 2003) was published and detailed that children should be encouraged to "make a positive contribution" to society. Soon after the Laming inquiry, the National Service Framework for Children, Young People and Maternity Services was published (DH, 2004). It recommended that:

> *"Children, young people and their parents participate in planning, evaluating and improving the quality of services"*

However, although this is recommended it cannot be assumed that this is the norm. In addition to the increasing amount of policy advocating for the involvement of children and young people in healthcare, over the last 20 years a considerable amount of research has been conducted regarding the views of children and how health professionals engage with them (for some examples please see Lambert, Glacken & McCarron, 2010; Livesley & Long, 2013; Quality Protects & Joseph Rowntree Foundation, 2002; Timms & Thoburn, 2003). A rapid review of research studies and consultations was carried out by the research centre at the National Children's Bureau (NCB) (La Valle, & Payne, 2012). It explored the views and experiences of children and young people in relation to physical and mental health services, public health and their involvement in health consultations. The evidence that emerged clearly suggested that children and young people want to be able to exercise their own choices and that they have opinions regarding their own healthcare. The NCB (La Valle, & Payne, 2012) recommended that there must be improved systems to allow the voices of children to be heard. More specifically, as echoed in Achieving Equity and Excellence for Children (DH, 2010b), it was identified that children and young people must be given opportunities to make their experiences known and have a say about what has (or has not) made a difference to their lives. However, it was still documented that children and young people

struggle to get their voices heard (DH, 2012b). The children and young people's health outcomes strategy (DH, 2012b), clearly recognised that children want to be listened to, to make decisions about their care and, when practical and suitable, to take the lead. (DH, 2012b).

More recently, a report published by the Children's Commissioner for England (Blades, Renton & La Valle, 2013) identified that children and young people are still being marginalised in decision-making. 'We would like to make a change: Children and young people's participation in strategic health decision-making' (Blades et al., 2013) reviewed 102 local health plans from health and wellbeing boards (HWBs), clinical commissioning groups (CCGs) and local authorities with reference to decision-making. It identified that there were clear gaps in the involvement of children, and only 28% of the plans specifically referenced children's participation. The report recommended that national bodies must actively encourage the involvement of children in strategic decision-making and develop resources and materials to assist with achieving this. Blades et al. (2013) also referred to local recommendations. This included local HWBs identifying a champion responsible for ensuring proactivity and the involvement of children in strategic decision-making. It further suggested that CCGs, HWBs, local authorities and local Healthwatch should have distinct systems in place for promoting and explaining to children what their contribution is and clear arrangements in place for monitoring participation.

Over the last decade, a number of organisations dedicated to involving children and young people in decisions about healthcare have become more widely recognised. As mentioned previously, the NCB (although established since the early 1960s) has for many years promoted the contribution that children and young people can make to their own lives. It has developed various initiatives that aim to engage children, including Young NCB, Young Inspectors, Voluntary Sector Support and the Young Children's Voices Network (YCVN), to mention a few (NCB, 2013).

In 2014 NHS England launched the Youth Forum. Twenty young people from all over England work in partnership with NHS England, Public Health England and the Department of Health to ensure that young people's voices are heard and that services for young people are improved. The NHS Friends and Family Test was launched in 2013 and gives the opportunity for patients to provide anonymous

feedback about their experiences of care. In 2015 children and young people contributed to this survey for the first time, and future inspections by the Care Quality Commission will increase the emphasis on involving the voices of children, young people and families who use a service.

Thus far, this chapter has addressed the political and historical development of involving service users in decisions about their health. However, it is noted that the involvement of children and young people in all aspects of healthcare is still inadequate. As a registered children's nurse and lecturer, I want to embrace the opportunity to involve young people in the education of nursing students, with an emphasis on ensuring that the voices of young people are no longer marginalised. Several models have been designed to guide the participation of children and young people in healthcare and are discussed in the next section.

1.4   Citizenship, participation and co-production

Over the last 50 years numerous models of citizen participation have been developed (Arnstein, 1969; Davidson, 1998; Hart, 1992; OCC, 2012; Treseder, 1997). Sherry Arnstein's ladder of participation, which was devised in 1969, is noted to be the most influential model of citizen participation. Arnstein (1969) proclaimed that citizen participation is citizen power and that sharing and redistributing power is fundamental in achieving true participation.

Roger Hart adapted Arnstein's theory and model to create the ladder of children's/youth participation. Hart (1992) developed a 'ladder of participation' to act as a set of principles about how to involve children and young people in projects (Figure 1.1). Hart recognised that children need to be included in projects with adults, as it is an unrealistic expectation that once they are 16, 18 or 21 they have the necessary skills and experiences to become participating adult citizens. Hart (1992) further suggested that young people can devise and manage complex projects with adults so long as they have some ownership. If ownership is ignored or an adult enforces their power over them, young people are unlikely to achieve and demonstrate their skills and competence.

In Hart's ladder the first three rungs represent non-participation, where children are manipulated or rewarded for taking part or have little or no choice about what they

are participating in. The next two rungs progress towards participation in terms of children's role being significant and the opinions of children are considered as worthy.

Figure 1.1:   Hart's ladder of participation (1992)[2].

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The sixth rung of the ladder represents the start of participation. Although the decisions may be initiated by adults, the decision-making process is shared. The penultimate rung of the ladder indicates that children initiate the decisions or projects and adults direct some of the actions resulting from these decisions. The final rung, which Hart (1992) explained as being a rare achievement, encompasses the child initiating the project and the child sharing decisions with an adult. This is a child-led project, with adults merely contributing their thoughts and opinions as needed. The objectives of my study were to involve young people in a worthwhile way and to ensure that their contribution was aligned with the top two rungs of the ladder; more specifically, that their involvement was not tokenistic. The level of participation and involvement of the young people is explored further in Chapter 4.

Over recent years Hart's model has been criticised for presenting a somewhat hierarchical structure. According to McLaughlin (2015), a ladder seems to suggest that the higher up the rungs you are the better the level of participation is, and what is ignored is the notion that certain tasks or activities may require different levels of

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[2] Eight levels of young people's participation in projects (the ladder metaphor is borrowed from the well-known essay on adult participation by Arnstein (1969), the categories are new) (Hart 1992:8.).

participation. Perhaps a more suitable model of participation is that presented by the Office of the Children's Commissioner (OCC) (2012, 2014), namely, the OCC Wheel of Participation (Figure 1.2). The wheel, which was adapted from Phil Treseder's (1997) Degrees of Participation model, bases its principles on there being no hierarchy and the view that participation can be significant in all the stages.

With reference to Hart's work and the OCC Wheel of Participation, it is essential that the work that young people design and manage is valued and that they can make a important contribution. Since the mid-2000s, health and social care organisations in the UK have been advocating the concept of co-production, especially in the mental health and disability sector.

Co-production was first described in the 1970s by an American economist, Elinor Ostrom, who examined the relationship between police, the prevention of crime and communities. The term was later used by Coote (2002) in a report published by the King's Fund entitled 'Claiming the Health Dividend', which emphasised the importance of the reciprocal relationship between the doctor and the patient.

Figure 1.2: The OCC Wheel of Participation (2012). Available from https://dera.ioe.ac.uk/20552/1/participation_strategy_2014_2015.pdf

Image removed due to copyright

The Social Care Institute for Excellence (SCIE) (2015) has produced several guidelines and recommendations for the co-production of services. They suggest that the fundamental values required for co-production to succeed are equality, accessibility, diversity and reciprocity (SCIE, 2015). More specifically in the case of children and young people, Aked and Stephens (2009) suggested that co-production moves beyond consultation in decision-making processes. Rather, co-production is viewed as presenting children and young people with the opportunity 'to be the change', recognising that they have unique skills, experiences and knowledge that they can contribute.

Recently, in healthcare the Coalition for Collaborative care (2016) has produced a seven-step model of co-production (Figure 1.3). However, to date this model has not been adapted for working with children and young people. The ethos of the model is that those who have lived the experience are best placed to advise on what services and support will make the best difference to their lives (Coalition for collaborative care, 2016).

Figure 1.3: Co-Production Model (Coalition for collaborative care, 2016). Available from http://coalitionforcollaborativecare.org.uk/wp-content/uploads/2016/07/C4CC-Co-production-Model.pdf

Image removed due to copyright

These models helped me to understand how I could engage with young people and how to ensure that their participation in simulation would be valued. In Chapter 4, I discuss how I worked with young people in my study and how they assisted in the co-production of a simulation session.

1.5   Involvement of service users in undergraduate nurse education

The matter of service user involvement in nurse education programmes has now been on the national government agenda for a decade (DH, 2009). In the 'Raising the Bar' review by Lord Willis (Health education England [HEE], 2015), he identified one of the main themes as the need to increase co-production and enhance the voice of the patient. In turn, Lord Willis (HEE, 2015) stated that although there is evidence of good practice regarding the involvement of service users in programme development and delivery, more needs to be done to actively involve them in nurse education. More specifically, it is essential that patients, students and trainees work together so that students and trainees have a better understanding of the patient's personal health journey (HEE, 2015). More recently, the Nursing and Midwifery Council (NMC) stated that users and carers must be involved in the co-production of educative programmes, including their design, delivery and evaluation (NMC, 2018a).

Fallon et al. (2012) recognised that adult service users and carers had been involved for several years in nursing research and the education of student nurses; however, this was not evident in the case of young service users. Most of the published literature was found to be focused on user involvement in the education of mental health and learning disability nurses (Atkinson & Williams, 2011; Blackhall et al, 2012; Fallon et al., 2012; Felton & Stickley, 2004; Forrest et al., 2000; Nazurjuk, Bernal & Southgate, 2013; Terry, 2012). This literature clearly recognises the important impact that service users and carers can have on the education of student nurses. However, despite the initiatives, organisations and government policy that emphatically propose that children and young people are included in healthcare, their contribution to undergraduate nurse education appears somewhat sparse, and there is a paucity of published research pertaining to this. This is explored critically in the literature review in Chapter 2. Further, simulation in a higher education institution (HEI) offers a unique opportunity to work with young people in a high-

fidelity simulated clinical environment with a focus on the training and development needs of students of CYP nursing.

1.6   Defining simulation

Within nurse education the term 'simulation' is often used with caution, at times with an assumption that it must incorporate the use of human patient simulators. However, there is an array of equipment, technologies and delivery modes that can be applied to simulation. In the context of simulation in healthcare, Gaba (2004) describes simulation as:

> "*A technique—not a technology—to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner*" (p. 2)

It is evident that this definition refers to simulation as a technique that imitates and replaces a real experience by creating a replica environment, apparatus or situation. Moreover, the emphasis on 'technique' supports the notion that simulation is not all about the technology, and sometimes no advanced technology is required. It is recognised that simulation does not simply rely on the use of highly advanced manikins. In addition to facilitating a scenario using human patient simulators, Billings and Halstead (2005) describe simulation as using a variety of resources to engage student learners; they suggest that role-play, computer software, games and case studies can be used to apply classroom theory to practice. More specifically within the nursing literature, Bland, Topping and Wood (2011) conducted a concept analysis and suggest that simulation is:

> "*A dynamic process involving the creation of a hypothetical opportunity that incorporates an authentic representation of reality, facilitates active student engagement and integrates the complexities of practical and theoretical learning with opportunity for repetition, feedback, evaluation and reflection*" (Bland et al., 2011, p. 668)

Bland et al (2011) emphasise the benefits of this modality of learning from the perspective of the student. Further, they suggest that simulation concerns replicating a scenario or situation that endeavours to represent 'reality'. For me, this definition

provides a holistic perspective on simulation and is fitting for the context of simulation in this study.

1.7 Historical context of simulation in healthcare

The concept of simulation originated in working environments that were considered hazardous and high-risk, with safe and practical training proving a challenge. Such industries included aviation, astronomy and the military (Bradley, 2006). However, it is within aviation that simulation has led the way through crew resource management (CRM) programmes (Bradley, 2006). Within healthcare, simulation evolved following the ground-breaking invention by Asmund Laerdal in 1960, namely, the 'Resusci Anne' part task trainer. Resusci Anne started as a training torso and head manikin for healthcare professionals to practice safe and effective resuscitation of patients. Since then the use of simulation and its associated technologies have progressed considerably. The inaugurator of HFS was David Gaba, an anaesthetist who also held a pilot's license and was familiar with CRM programmes and their success in training staff. Thus, in the 1980s he led a team of experts to develop the first human patient simulator and in turn created the first simulated clinical environment.

1.8 Simulation in nurse education

Simulation in nurse education is not a new concept and is widely recognised as a form of pedagogy. Simulation has developed rapidly over the last two decades, and the use of human patient simulators provides a more realistic learning experience as they appear to breathe, talk and have palpable pulses. A key component of simulation is the ability to facilitate students' development of clinical skills in a safe environment, whilst attempting to mimic reality (Wilford & Doyle, 2006). The Simulation in Practice Project (NMC, 2008) recommended that simulated learning could provide students with learning opportunities that they are not exposed to in practice. Following this, the NMC (2010) stipulated that simulation can account for 300 hours of practice and can be implemented in an educational setting. In the new Standards for Education (NMC, 2018a), the number of simulated practice hours in a curriculum is not specified; however, the NMC advise that simulation is integrated in a 'proportionate' way. Therefore, it seems that there is flexibility for education providers to increase the number of simulated practice hours; however, the NMC (2018b) state that these hours must include direct contact with a sick or healthy

person. This caveat seems to indicate that simulation with a human patient simulator would not satisfy this requirement. There are numerous papers that support the use of simulation in nurse education (some examples include Baillie & Curzio, 2009; Berragan, 2014; Traynor et al., 2010; Wilford & Doyle, 2006). An evaluative study by Baillie and Curzio (2009) established that a high percentage of students and facilitators reported that simulation supports learning from mistakes. Whereas Traynor et al. (2010) reported that students can repeatedly practice a skill without causing harm to patients and receive feedback on their performance, Felton et al. (2013) found that nursing students reported an increase in relation to their interpersonal and communication skills. Berragan (2014) found that simulation assisted in student nurses having an identity as a nurse and strengthened the development of skills. Here, it is recognised that there are unequivocal benefits to simulation, but, as Bland et al. (2011) reported, for students to have a positive learning experience simulation must be authentic and replicate real life.

1.9   Realism, authenticity and fidelity in simulation

Within simulation the terms realism, authenticity and fidelity are often used synonymously but equally can be misunderstood. It is imperative that within this thesis these terms are used accurately, and they are explored subsequently.

According to Rudolph, Simon and Raemar (2007) realism in simulation is defined in three components: physical, conceptual and emotional/experiential. Physical realism relates to what can be touched or seen, for instance the equipment or manikins. Conceptual realism is concerned with decision-making, problem-solving and prediction. Emotional/experiential components of realism in simulation relates to the holistic experience of the simulation and the positive or negative feelings evoked from that experience (Rudolph et al, 2007; O'Leary, Pegiazoglou, McGarvey, Novakov, Wolfsberger & Peat, 2018). Thus, in simulation, a situation or scenario must represent accurately what would essentially occur in practice. Hellaby (2013) suggested that a simulation session is truly realistic when participants cannot distinguish between the simulation and actual practice. However, this is rarely achievable, and there must be some understanding that part of the scenario may not represent reality to the participant but should feel authentic.

Authenticity is described as an essential attribute of simulation in undergraduate nurse education (Bland et al., 2011). There are, however, distinct associations between authenticity, realism and fidelity. Rystedt and Sjoblom (2012) point out that replicating reality through fidelity is the essential progression towards authenticity being the foundation for simulation. Fidelity in simulation has been defined as:

> "*The extent to which the appearance and behaviour of the simulator∕simulation match the appearance and behaviour of the simulated system*" (Maran & Glavin, 2003, p. 22)

In terms of simulation within nurse education, Baillie and Curzio (2009) suggest that fidelity concerns the accuracy of the simulation and the experience is most realistic when the fidelity is high. Similarly, Jeffries (2007) asserts that fidelity is closely connected to realism and is the key to a successful simulation replicating reality. Moreover, fidelity in simulation is often referred to in terms of being low, medium or high. Basak et al. (2016) suggest that the technologies used to simulate practice have progressed over the years from low fidelity to high fidelity; they describe low fidelity as using part task trainers (for example, IV arms) and high fidelity as incorporating the use of highly advanced computerised manikins (SimMan 3G®, for example). Other authors suggest that the fidelity of simulation involves much more than just the choice of manikin, with the equipment, environment and psychology also contributing to the level of fidelity achieved (Hellaby, 2013). In turn, Maran and Glavin (2003) propose that engineering (or environment) fidelity is the extent to which the environment or training device mimics real practice, whereas psychological fidelity is the degree to which the participants believe the scenario to be realistic (Hellaby, 2013; Maran & Glavin, 2003).

Bland, Topping and Tobbell (2014) recognise that increasing the level of technological fidelity does not automatically maximise authenticity. More specifically, they state that there is a distinguishable difference between fidelity and authenticity in that fidelity is the replication of an objective reality and authenticity is the subjective interpretation of, or response to, that given situation. Moreover, there are some experts in simulation (such as Hellaby, 2013) who prefer not to use the term 'fidelity' owing to the inconsistency and misuse of its meaning.

To maximise perceived authenticity, the ability to 'suspend disbelief' is salient when participating in a simulated scenario. Dieckmann, Manser, Wehner & Rall (2007) explain that simulation relies on the participants engaging in a fictional contract. The key to success is being able to accept that there will be aspects of the scenario that do not appear real and that the participants need to sign up to the idea of 'willing suspension of disbelief'. The notion of suspension of disbelief was coined in 1817 by poet and philosopher Samuel Taylor Coleridge, who suggested that readers of fiction would suspend their doubt and believe in every aspect of what they were reading (Coleridge, 1817). In simulation, Muckler (2017) suggests that participants need to be able to suspend disbelief and become so immersed that they accept that what is happening is real. However, Dieckmann et al. (2007) suggest that the participants have an essential role in this process and make the decisions about when to suspend disbelief. Although not without challenges, it is crucial that students allow themselves to become immersed in simulation as this ultimately enhances the learning experience (Davis et al., 2017; Pike & O'Donnell, 2010). That said, Reilly and Spratt (2007) advocate that the facilitator must provide the student with relevant cues for when to suspend disbelief as immersion in a scenario increases.

1.10 Summary and orientation to the thesis

This chapter has presented the background and a policy review of service user involvement in healthcare, with specific reference to children and young people. Service user involvement in healthcare and nurse education has progressed over the last two decades and is well supported by policy. However, it is still recognised that the voices of children and young people are not being represented to their potential.

Using a systematic approach, Chapter 2 provides a critical integrative review of the literature relating to young people's involvement in the training of undergraduate student nurses and their education. Chapter 3 presents a critical and reflective discussion about the methodological approach used for this study. Chapter 4 provides a reflective discussion of the preparatory work that was undertaken with the young participants. The training and development of the young participants was a significant part of this work, and it seemed pertinent to dedicate a chapter to this. In chapters 5, 6 and 7 I present the findings from the data. Chapter 8 provides a critical

discussion of the findings, and in the final chapter, Chapter 9, conclusions and recommendations are proposed. Please see figure 1.4 which provides an outline of the study.

Chapter 2

Literature review

2.1   Introduction

The previous chapter addressed the history and background of service user involvement in UK healthcare, the involvement of children and young people in healthcare and the development of simulation in nursing. What follows in this chapter is a robust, rigorous and critical integrative review of the literature.

Broome (1993) suggests that an integrative review is applicable when the aim is to establish knowledge about a specific concept and to draw on past research to establish overall conclusions. Whittemore and Knafl (2005) suggest that an integrative review enables the inclusion of a variety of methods, namely, experimental and non-experimental research. Furthermore, an integrative review facilitates a critical in-depth review of the phenomena to be studied, a review of theoretical concepts and a critical appraisal and analysis of evidence (Broome, 1993). In keeping with Mason (2018), it was important that I understood what my research was about and the nature of the phenomena being studied. For me, an integrative review was selected as it enabled a summary of empirical and theoretical literature whilst providing an in-depth understanding of the topic to be studied. More specifically, an integrative review was deemed an appropriate approach as it facilitated a review of current and past evidence relating to young people's involvement in the education of undergraduate student nurses and an exploration of the theoretical constructs of the new sociology of childhood. This included central concepts such as agency, voice and choice.

First, I begin with reviewing the work of key theorists of the new sociology of childhood, drawing specifically on the work of James and Prout (1997), James and James (2004), Jenks (2005) and Mayall (2002). This is then followed by a critical in-depth review of the literature relating to children and young people's involvement in nurse education. Systematic methods have been used to ensure a robust and rigorous argument and to critically determine both the level and the quality of the

evidence that currently exists. The decisions taken in relation to what counts as evidence and what has been included are explained.

2.2 Theoretical framework and the social construction of childhood

The underpinning theoretical framework of this thesis is the new sociology of childhood (Cosaro, 2005; James & Prout, 1997; Mayall, 2002), which identifies children and young people not as passive objects in society but as competent and active agents. In section 2 of this chapter, the concepts of childhood and agency are critically discussed.

Alanen (2001) and Qvortrup (2009) have been prominent scholars in the development of childhood sociology and the structural approach to societal workings. In 1987 Qvortrup led the Childhood as a Social Phenomenon Programme (CSP), which explored the legal, economic and social status of children in 16 industrialised countries (Qvortrup, 1991). This work attracted interest in the UK, notably that of James and Prout, who included Qvortrup's work in their seminal collection of papers about the new sociology of childhood (James & Prout, 1997).

Prout and James (1998) advocated that the study of childhood needed to progress beyond the psychological theories that conceptualise childhood as a time of development or 'becomings'. They argued that children should be viewed as social agents, as 'beings' who are shaped by and shape structures and processes, rather than children who 'become' adults. Such sociological approaches explore matters relating to the socialisation of the child and examine how children learn to integrate or become members of the society in which they live (Gallacher & Kehily, 2013).

Scholars worldwide in both developed and developing countries published work on how they had worked with children and, more specifically, studies focused on the social construction of childhood. Included in the series of papers collated by James and Prout's (1997), Solberg (1997) conducted several studies about the role of the child in the home (Solberg, 1987; Solberg & Danieisen, 1988; Solberg & Vesty, 1987). More precisely, Solberg and Danieisen (1988) studied the daily routines of ten families living in different areas of Oslo. The division of labour in domestic chores was explored in depth, with Solberg and Danieisen concluding that children contribute significantly to household work. This work helped me to understand more

about how children are positioned in different societies and that I needed to consider how the young participants in my study might not all be positioned equally.

During the next 20 years, criticisms of the traditional perception of children as immature, irrational and incompetent individuals impelled sociocultural researchers to research childhood or children in a different way. Sociocultural researchers began to focus more on the views and experiences of children and how childhood experiences differ depending on time and place.

What follows illustrates the challenges, over time, that created the space for scholars to think differently about children and enable them to challenge the notions of what it is to be a child and what is meant by childhood. This is important in terms of the context for my study. It was important that I explored the concept of what it is to be a child and what is meant by childhood, as, in keeping with Broome (1993), I needed to understand the phenomena being studied, that is, young people's involvement.

2.2.1 What is a child?

Over the years, numerous terms have been assigned to children and young people. These have commonly been differentiated by age and, although not an exhaustive list, include neonate, baby, infant, toddler, child, teenager, adolescent, youth, young person and young adult. However, such terms are often used interchangeably with no universally agreed terminology for what constitutes a child or young person.

In the UK, the term 'young person or people' has been widely accepted as a term for the older child. Whereas the National Service Framework for Children, Young People and Maternity Services (DH, 2004) suggests that children are all those who are under the age of 19, the Association for Young People's Health (AYPH) (2016) refer to young people as those between 10 and 24 years old. Spanning 14 years, this period is perhaps defined according to the continuing development of the adolescent brain. During adolescence, young people transition through a rapid period of development, not just physically, but emotionally, mentally and socially. During the teenage years the brain develops considerably and continues to do so until the young person is around 25 years old (Johnson, Blum & Giedd, 2009; Konrad, Firk & Uhlhaas, 2013). Such scholars support the suggestion provided by the AYPH (2016) that those up to the age of 24 constitutes being a young person.

Hockey and James (2003) suggest that age is key to defining what a child is and is contextualised according to legal imperatives and consumer practices. Examples include the age of criminal responsibility, leaving school, consent to medical practices, access to contraception, consensual sex, employment and the right to vote. In addition, these vary considerably across different countries and there are global discrepancies regarding the law, which further complicate the positioning of children. For example, in England a young person can be married legally and give medical consent at 16 years, yet they are not permitted to vote or purchase alcohol until they are 18 years old. In China, the legal age of consent for sexual intercourse is 14 years; in the USA it varies from 16 to 18, depending on the State in which the person resides, and the lowest age of consent (11) is in Nigeria. Thus, there are clear inconsistencies worldwide regarding the legally enforced or expected age for children and young people to undertake certain activities. Within the countries in the UK there are further disparities, more specifically in relation to being able to vote in a general election. In England, the relevant age is 18, whereas in Scotland it is 16.

A further contentious topic relates to when it is deemed appropriate to leave a child at home alone and when it is reasonable to leave a child unaccompanied. This is perhaps due to there being no jurisdiction that states when it is acceptable for this to occur. That said, it is an offence to leave a child alone if they are considered at risk (GOV.UK, 2019). Therefore, the onus is on the parent or carer to decide whether a child can be left alone, which places a significant responsibility on the person making that decision. The NSPCC (2019) provide guidance and suggest that children under the age of 12 rarely have the maturity to be left at home for a long period of time. However, this is ambiguous as there is no definition of what is considered a 'long' period. In turn, it is recognised that children develop at different rates and some 12-year-olds still may not have the maturity to be left alone. Moreover, global stances on this subject vary considerably.

For example, Solberg's (1997) research into the daily lives of Norwegian children identified that 10-year-old children can competently undertake household chores. Solberg argued that these children manage to appear 'older' than their actual age, which enables their parents to trust them and leave them at home alone. Another example is drawn from China, where internal migration is a major national and international cause for concern (Wyness, 2015). Migration from the countryside to

the cities has increased so much that residents are only granted citizenship if they have been permanent residents and thus have minimal access to housing, education and employment (Luo, 2012). This has resulted in many rural children being left behind with relatives and, at times, which is more concerning, left to fend for themselves (Liang et al., 2008). Liang et al. report that as many as 58 million children are reported to be 'left behind' whilst their parents seek work in the cities, with around 30% of children seeing their parents less than once a year.

In the UK, further complexities relate to the sexual activities of young people. The Sexual Offences Act 2003 states that it is considered statutory rape to have sexual intercourse with someone aged 15 years old or under. In turn, children are considered to lack the capacity to consent to sexual intercourse if they are less than 16 years old. Conversely, the landmark case of Gillick v West Norfolk (House of Lords and Department of Health and Social Security, 1984) resulted in the publication of the Fraser guidelines. These guidelines state that children under 16 can seek contraception and request a termination of pregnancy without the consent of a parent if they have been deemed to have the competence to make this decision.

The examples discussed above demonstrate the complexities related to deciding when a child is a child and when he/she becomes an adult, capable of making decisions without the consent of an adult.

2.2.2 Defining childhood

According to the UNCRC (UNICEF, 1989), childhood encompasses a period of human existence that starts at birth and ends at 18 years of age. However, despite being an internationally agreed definition, it is defined by age and thus fails to identify context and experiences, and its application to the social world is somewhat meaningless. More specifically, James and James (2004) identify that the 'best interests principle' of the convention is based on each individual child, and best interests will therefore be determined within the cultural context in which a child resides. In turn, the UNCRC (1989) does not imply rights, and there are global differences in the legal, political and cultural influences over the rights that a child has. Furthermore, Norozi and Moen (2016) suggest that the concept of childhood is neither natural nor universal, as societies throughout the world vary in what they consider a child or childhood to be. Given this, it is not surprising that what

constitutes 'childhood' and being a child has been widely discussed in the literature. James and James (2008) suggest that social constructionism was pivotal in beginning to understand children and childhood.

2.2.3 Childhood as a social construction

The concept of social construction was first introduced in 1967 by the sociologists Peter Berger and Thomas Luckman in their book '*The social construction of reality*'. The authors proposed that the taken-for-granted 'reality' of day-to-day life originates from people's interactions with each other and the cultural and natural environments in which they live. Furthermore, James and James (2008) suggest that social construction is a theoretical standpoint that explores the ways in which 'reality' is negotiated in everyday life through people's interactions and discourses. Such concepts were key in contributing to the development of childhood studies, specifically in relation to discussions about whether childhood was a natural or social phenomenon (James & James, 2008). Norozi and Moen (2016) propose that the concept of childhood being socially constructed suggests that childhood is not a natural process and it is society that shapes the decisions of when a child is 'being' a child and when a child 'becomes' an adult. That said, such terms are representative of the socially constructed meanings of the child and childhood and suggest that a child is on a transitional pathway to becoming an adult. As key childhood theorists explain, childhood is positioned between being a child and becoming an adult (James & James, 2004; James, Jenks & Prout, 1998; James & Prout, 1997; Jenks, 2005; John, 2003; Mayall, 2002; Wyness, 2015).

An early influential piece of work on 'childhood' was described by Ariès (1962) in his '*Centuries of childhood*'. Ariès (1962) proclaimed that childhood did not exist in medieval times and emerged after the Middle Ages. Drawing on medieval drawings and artefacts, Ariès suggested that childhood was not depicted as a significant part of the life course. Rather, as soon as children were no longer infants, they engaged and participated in the adult world. Ariès proposed that it was the growing concern for the welfare and protection of children that sparked the interest in studying childhood. However, since its publication, there have also been notable critiques of his work (Hendrick, 1992; Pollock, 1983). There were several key areas that Hendrick (1992) and Pollock (1983) challenged. They suggested that the historical

drawings and artefacts were unreliable, that he over-relied on uncommon sources and the confines enforced on the artistic methods of that era were ignored. That said, Heywood (2001) recognised that Ariès' work provided a springboard for scholars to think critically about children in their own society and, as such, marked a significant turning point for childhood studies.

In a later work, Jenks (2005, p. 6) asserts that childhood is a "totalising concept", in that everyone at some point has existed as a child and it is the only true common experience that humans share. Although Jenks (2005) proposes that childhood is a period that most of society will experience, others suggest that it is a permanent structure, with the people within it being permanently replaced (Qvortrup, 1991). Thus, as Qvortrup suggests, childhood is a fixed construct and it is only those entering and leaving that alter. James et al. (1998) suggest that describing childhood as a social construction means the acceptance that there are no "taken-for-granted meanings" (p. 27). The authors explain further that although as individuals we all have knowledge about children and childhood, that is, we have all experienced it, the socially constructed meaning cannot reliably draw on such knowledge.

Over the last two centuries, the disciplines of sociology and psychology have contributed significantly to understanding childhood and child development. In the early twentieth century, it was the psychology of child development that dominated research, identifying the child as transitioning through childhood to adulthood in terms of physical development, age and cognitive ability. In later years, such approaches were heavily criticised as they perceived children and young people as subordinate to adults and only viewed their interests and activities in relation to how they would transition into adulthood (James, Jenks & Prout, 1998; James & Prout, 1997). However, it cannot be overlooked that psychological approaches to understanding children and childhood have a more substantial history and include five key approaches, namely, physiological, psychodynamic, behavioural, humanistic and cognitive approaches (McLaughlin, 2015).

2.2.4 Psychological approaches to childhood

Whereas the physiological approach focuses on the biology of behaviour, the psychodynamic approach associated with the work of Freud (1915) argued that it is the unconscious mind that controls human behaviour. However, behaviourist

approaches (Pavlov, 1928; Skinner, 1938) challenged this theory further by focusing more on behaviour than the mind, proposing that behaviour can be learned or adapted through operant conditioning. However, others have suggested that the behaviourist approach is too mechanistic, with a tendency to disregard the mind, and is unable to describe complex behaviours (Greig, Taylor & Mackay, 2013). The humanistic approach challenges both the psychodynamic and the behaviourist approach. The work of Maslow (1954) developed the hierarchy of needs framework, as he identified that there was a lack of the human element within psychology. Whereas some consider this a significant approach in the development of counselling, others have critiqued this as lacking in scientific methodology or theory (Greig, Taylor & Mackay, 2013). The cognitive psychological approach is largely associated with the work of Piaget (1936) and Vygotsky (1978). The cognitive development theory focuses on how a child builds a mental picture of the world (Piaget, 1936). Piaget viewed cognitive development as a process and challenged the concept that intelligence is a fixed attribute. Conversely, Vygotsky proposed that:

> "*Learning is a necessary and universal aspect of the process of developing culturally organized, specifically human psychological function*" *(*1978, p. 90).

Thus, in contrast to the theory of Piaget (1936), who advocated that a child's development must precede learning, Vygotsky (1978) stated that social interaction is essential in the development of cognition. However, it was during the 1980s that sociocultural researchers became disgruntled with the notion of psychological development and socialisation being the dominant concept in childhood studies within the social sciences.

2.2.5 Human 'beings' and human 'becomings'

Jenks (2005) proposed that it is difficult to imagine a child without conceiving them as developing into an adult. Furthermore, Jenks suggested that to develop a good understanding of an adult without considering them as having been a child is equally a challenge. James and James (2012) identified that children are less developed than adults in many ways, physically, mentally, emotionally and socially.

However, sociologists have suggested that there are further differences between a child and an adult. Qvortrup (1994) suggested that children and adults have

fundamental differences, described as child 'human becomings' and adult 'human beings'. Lee (2001) explains this as follows: a 'human being' is expected to be reliable, complete, self-controlling and independent, whereas a 'human becoming' will be changeable and lacking in self-control and independent thought. Furthermore, Lee (2001) proposes that the difference between beings and becomings is that between being complete and independent and being incomplete and dependent. Thus, such concepts indicate that a child is constrained until he/she becomes an adult and enters adulthood. Childhood is considered a period that precedes adulthood; however, global disparities exist regarding what constitutes childhood and being a child.

2.2.6 Emergence of a paradigm for the new sociology of childhood

By the 1990s, a significant amount of research had emerged on the conceptualisation of childhood and sociocultural researchers identified prominent themes. Subsequently, this led to the establishment of a new paradigm of childhood studies, often referred to as the 'new sociology or social studies of childhood'. As frequently cited, James and Prout (1997) discuss the differences between the two approaches of psychology and sociology, from which they created the paradigm of the new sociology of childhood, incorporating six key features (Table 2.1). As Gallacher and Kehily (2013) advocate, the intention of James and Prout was to produce a set of principles (Table 2.1), which sociocultural researchers could refer to in their approaches to childhood studies. In section 2.2.9, I explain how this helped me think about how I wanted to carry out my research and the significance of ensuring that the voices of the young participants were heard.

Although not integrated into the paradigm, a further development in the new sociology of childhood was the concept of children as 'beings' and 'becomings'. As a 'being', a child has an active role in constructing their life, whereas a 'becoming' child is perceived as passive rather than active (James, Jenks & Prout, 1998; Qvortrup, 1991).

2.2.7 Children as social actors and agents

The notion that children and young people should be perceived as independent social actors/agents is key to the new sociology of childhood. In my study, the young

participants were invited to be involved as social actors and agents. The terms social actor and agent concern the capacity of children and young people to make decisions about what they do and to have the freedom and independence to express their own views. Mayall (2002) suggests that, although the words 'actor' and 'agent' are derived from the same Latin meaning, the two words have deviated somewhat. Mayall considers children as social actors, who act on subjective desires and have an ability to express their wishes and demonstrate jealousy, pleasure and other emotions. A social agent, on the other hand, goes beyond this and is described as someone who negotiates and interacts to make a difference within a group of social constraints or assumptions (Mayall, 2002). In agreement with Mayall, Oswell (2013) suggests that:

> *"children are not simply beings, they are significant doings. They are actors, authors, authorities and agents. They make a difference to the world we live in"* (p. 3)

Conceptualising children as having 'agency' means considering them as being capable of making decisions about themselves and accepting that such decisions will have consequences (Mayall, 2002). Children are considered as agents, constructing knowledge as active participants and through their daily experiences. However, McLaughlin (2015) proposes that children's agency is constrained, but the constraints are no different from those experienced by adults. Perhaps, however, children may be more constrained owing to the power relations between adults and children. Furthermore, the constraints are more complex for children as adults are expected to protect children, and children are dependent on adults for many years (McLaughlin, 2015). That said, there are similarities between the agency of adults and that of children, in that, like an adult, a child is rooted within the complexities of a social system, which includes family, religion, education and culture, enveloped by other structures such as gender and class. This brings to the forefront the structure–agency debate, which was introduced some time ago by Karl Marx, Max Weber and Emile Durkheim (James & James, 2008). The structure–agency debate concerns the competing arguments regarding the ability of individuals to act independently of social structures. Social structure relates to the institutional and relational components that constitute a society. For example, institutional components may include the law, government and economic systems, whereas relational components

may be considered as class, gender, ethnicity and generation. In the context of my study, I had to consider the issues associated with generation, namely, the perceived power relations between adults and children.

2.2.8 Child–adult relations

Mayall (2002) identifies that generation is a key concept for childhood studies and is integral to understanding child–adult relationships. Childhood is recognised as a period when people need protection as they understand less and possess less strength and maturity in comparison to adults. The concept of requiring protection also implies being provided for and, as a result, suggests an unequal relationship of power (Mayall, 2002). Although Mayall (2002) identifies that the majority of children will succumb to this unequal relationship of power, Ennew (1995) proposes that some groups of children, more specifically street children, do not have the privilege of protection and provision. John (2003) further explains that such children work and care for themselves, are enterprising and resilient and do not require society to 'rescue' them and, as such, have autonomy and power. However, such autonomy and power are limited to a minority group of children and not representative of children and young people worldwide. Furthermore, Valentine (2011) suggests that children's agency materialises from the constant power relations between children and adults, more specifically in the context of children's vulnerability. Valentine argues that children may perceive themselves as vulnerable and requiring protection from adults. Contentiously, Wyness (2015) suggests that this may make a researcher question whether children as participants should have the freedom of agency. However, doing so would deny the rights of children and young people to have their voices listened to.

Another way of further understanding the relations between adults and children is through reference to Lukes's (1974) work on power. Lukes (1974, 2005) describes power as a three-dimensional construct. The least effective form of power involves adults making all the rules that children should follow and being anxious about sharing power. The second least effective construct of power is that based on dishonesty and deceit, with the adult providing misleading choices or information. The most influential type of power is that which is based on no choice, so much so that the person wants to behave in a certain way as they have internalised their own

oppression (Lukes, 1974). In keeping with Lukes (1974, 2005), Alderson (2000) identifies that adults may worry that if they give children a small amount of power the children will want more. Thus, devolving power is avoided and the adult remains the controlling and powerful person in the relationship. As a consequence, children and young people can often feel oppressed and powerless, and internalising these feelings means that they often convince themselves that they are worthless (John, 2003). Drawing on this work made me consider the significance of the relationship between myself and the young participants and that I had to avoid the temptation to hold on to my power as researcher and lecturer. Gallagher (2008) reflects on how his attempt to empower his research participants sometimes had the opposite effect, with their refusal to accept the power that was devolved to them. Like Gallagher, I wanted to ensure that I empowered the young participants in my study, and thus the issue of power was at the forefront of my thinking and actions throughout the research study. I was aware that as an adult researcher there would be an inevitable power relationship between myself and the young participants. This is addressed further in Chapter 4 in my discussions about working with the young people.

Despite concerns raised by Alderson (2000) and Lukes (1974) regarding power and child–adult relations, Mayall (2001, p. 3) asserts that:

> "*Children are not only 'actors' – people who do things, who enact, who have perspective on their lives. They are also understood as agents whose powers to influence and organise events – to engage with the structures which shape their lives – are to be studied*"

Recognising that children and young people are powerful agents in constructing their own lives was considered an intrinsic component of my research study. By inviting young people to participate and become involved in the education of CYP nursing students, it was hoped that they would feel valued and oppression would be imperceptible. The significance of the voices of children and agency is inherently linked to the concept of participation. In order to understand this more, I applied Prout and James' new paradigm of childhood to my research.

2.2.9 Application of the paradigm of the new sociology of childhood

I drew upon the paradigm of the new sociology of childhood (please see table 2.1) to help me understand more about structure and agency and the significance of involving young people in this study. What follows is a discussion of the paradigm and how it related to my study.

Childhood as a social construction is discussed earlier. However, for this study I was able to identify that the social construction of the young participants was represented in many ways. As college students, I knew I would be working with an adult gatekeeper to get permission and consent for them to be involved in the study.

In keeping with Prout and James (1997) it was important that I was mindful that childhood is a variable of social analysis. I was aware that although they were all college students, their views and perspectives could differ and would be influenced by their gender, class, culture and ethnicity. The young people varied in their opinions in different stages of the study. Although consensuses were reached, there was no universally agreed way to do things, and it was considered that their views could be influenced by culture, class, gender and ethnicity. I also identified that the social relationships and cultures of the young people were worthy of study. The aim was to ensure that their participation was free from adult interference, specifically when their views were sought. My role was to listen and to provide support when needed, ensuring that I did not influence the views and decisions of the young participants. The young participants were actively involved in the construction of their own lives and the lives of those who were around them. The young people participated in a study that was relevant to their lives and they were actively involved in shaping and co-producing an aspect of nurse education. Although an ethnographic approach was not possible for this study (see Chapter 3, section 3.5), a sociological stance was taken through adopting an exploratory qualitative methodology, enabling and privileging the voices of the young participants. Finally, I involved the young people in nurse education and responded to their views. This provided them with opportunities to construct their lives, and I valued their perspectives on what it is like to be a young person.

Table 2.1:   Paradigm for the new sociology of childhood (James & Prout, 1997, p. 8)

Paradigm for the new sociology of childhood	
1	Childhood is understood as a social construction. As such, it provides an interpretative frame for contextualising the early years of human life. Childhood, as distinct from biological immaturity, is neither a natural nor a universal feature of human groups but appears as a specific structural and cultural component of many societies.
2.	Childhood is a variable of social analysis. It can never be entirely divorced from other variables such as class, gender or ethnicity. Comparative and cross-cultural analysis reveals a variety of childhoods rather than a single and universal phenomenon.
3.	Children's social relationships and cultures are worthy of study in their own right, independently of the perspective and concerns of adults.
4.	Children are and must be seen as active in the construction and determination of their own social lives, the lives of those around them and the societies in which they live. Children are not just passive subjects of social structures and processes.
5.	Ethnography is a particularly useful methodology for the study of childhood. It allows children a more direct voice and participation in the production of sociological data than is usually possible through experimental or survey styles of research.
6.	Childhood is a phenomenon in relation to which the double hermeneutic of the social sciences is acutely present. That is to say, to proclaim a new paradigm of childhood sociology is also to engage in and respond to the process of reconstructing childhood.

I recognised the significance of the new paradigm for the sociology of childhood created by James and Prout (1997) in relation to how I would involve the young participants in my research. In keeping with the paradigm, I wanted to ensure that the young people were valued and were not viewed or involved as passive agents,

rather that they were active agents within their own worlds. This is explored in more depth in later chapters as I critically examine how I worked with the young people and the significant impact that their involvement had for them and the nursing students. In my study I hoped that I would succeed in encouraging the young people to express their wishes and desires, but it emerged that this was at times thwarted, with adults exerting their power over the young participants and limiting their opportunities to participate, engage and be involved. This is explored further in later chapters.

In summary, the development of the new sociology of childhood and the movement towards children and young people having agency is significant in understanding how to work effectively with children and young people in health and social care. In a society that is still dominated by adult forces, the 'doing as you're told' philosophy still exists, and adults may assert their authority over children and childhood (James & James, 2004). Therefore, one of my objectives was to develop strategies and initiatives to involve young people in the co-production of simulation to ensure that they felt valued, their voices were heard and they were active agents.

In keeping with Broome (1993), this section has explored the phenomena to be studied in the literature review (children and young people's involvement) and the theoretical concepts (social construction of childhood and agency). Next, I provide a critical review and appraisal of the literature, which Broome (1993) identifies as the last stage of conducting an integrative review.

2.3   Critical review and appraisal of the literature

According to Whittemore and Knafl (2005), there are three stages involved in an integrative review, that is, a critical review of the phenomena to be studied, a review of theoretical constructs and a critical review and appraisal of the literature, with the latter stage involving five sub stages. These sub stages include problem identification, literature search, data evaluation, data analysis and presentation. What follows is an adaptation of this framework, with an integration of systematic review methods.

2.3.1   Problem identification

In this stage, Whittemore and Knafl (2005) state that a clear question for the review should be identified. However, it was important to initially identify the aims and objectives of the review, as this would assist with the formulation of the review question.

2.3.2 Aims

The aims of the literature review were threefold: to determine critically the level and quality of the current evidence base; to determine what is known about the topic of young people's involvement in simulation; and to determine what methods have worked well or less well.

2.3.3 Objectives

- To use systematic methods to review and appraise the evidence relating to the involvement of children and young people in nurse education. This will include a critical review of the methods used to determine the level and quality of evidence that currently exists.

- To ascertain the outcome and impact of such involvement for the children and young people, student nurses and those involved in their education.

- To critically determine how children and young people and students of children's nursing have been positioned in research relating to their involvement in nurse education.

- To provide further context and background to the study and highlight areas for further investigation.

- To critically assess the research methods used in previous research studies.

2.3.4 Developing the review question

The first step in any review requires the development of a review question. As Gray (2014) points out, this is necessary as search questions lead to the research questions that are developed from the review outcomes. Aveyard (2014) adds that a vague or poorly defined question could result in the reviewer having an insurmountable amount of literature to deal with, which could jeopardise their ability to answer the question. In turn, a search question that is too specific may lead to

there being very little (if any) literature that can be included in the review (Aveyard, 2014). This is a moot point, given what follows.

Beecroft, Booth and Rees (2010) suggest using either the Population, Intervention, Comparison and Outcomes (PICO) framework or the Setting, Perspective, Intervention, Comparison, Evaluation (SPICE) model to help develop the question. They maintain that PICO is best suited when researching healthcare interventions, whereas the SPICE model is more appropriate for questions most likely to have been studied using qualitative approaches. Booth (2006) has noted the limitations imposed by guidance that limits any search to experimental studies. The PICO framework is founded on the notion of an intervention with a definable outcome, thus the framework is limited. Given Booth's criticism and knowing that I was likely to find a dearth of quantitative research related to the topic, I elected to use the SPICE framework as I felt this would ensure that the question I derived would enable me to search through all the available evidence.

In addition, some commentators note that the SPICE framework can be adapted to meet the needs of the review (Beecroft, Booth & Rees, 2010). Given this, and as no comparison element was identified, I started with the 'S', 'P' and 'I' headings (Table 2.2).

From this, the following initial search question was generated:

What are the perspectives of children and young people, undergraduate students of CYP nursing and university lecturers about involving children and young people in simulation?

Table 2.2:   Application of the SPICE framework

Setting	Higher education institution
Perspective	Children and young people CYP nursing students Lecturer
Intervention	The involvement of children and young people in the facilitation of simulation with CYP nursing students
Comparison	Omitted
Evaluation	Omitted

2.4   Literature search

The second stage in Whittemore and Knafl's (2005) framework is the literature search. A clearly defined literature search strategy is essential for enhancing the rigour of the review, as unfinished or biased searches can result in potentially inaccurate results (Cooper, 1998; Whittemore & Knafl, 2005). Moreover, an important task for any researcher is to establish the quality and level of existing knowledge such that they avoid any repetition and ensure that the pursuit of new knowledge is achieved. In keeping with Gray (2014), I wanted to establish what knowledge existed, identify the current gaps in knowledge worthy of further exploration and challenge current practice related to young people's involvement in simulation. My intention was to explore and critically appraise current evidence in order to provide a synthesis of existing evidence. However, I have provided a critical discussion related to my initial (stage 1) and subsequent (stage 2) searches and why it was necessary for me to revisit my initial search question and criteria. Although some advocates for evidence-based practice, such as the Cochrane Collaboration (CC)[3], have suggested that only evidence considered to fall within the top echelons of the hierarchy of evidence (randomised controlled trials [RCTs] or quasi-experimental studies) should form the basis for decision-making, others have argued that the inclusion of all evidence provides richer results (Noyes, Popay, Pearson, Hannes & Booth, 2011). In the past, arguments for each position have tended to be polarised; however, what mattered for me was the scope and type of evidence available. An early scoping exercise led me to conclude that there was a dearth of evidence and that what existed tended towards descriptive rather than experimental or quasi-experimental approaches. Still, it seemed reasonable to apply systematic methods to search for and appraise critically all the evidence to ensure that I could determine the quality and level of evidence already in existence, learn from what has worked well for previous researchers and avoid any notable pitfalls. My position on this concurs with the Medical Research Council's (MRC) (2008) advice that it is necessary to develop insight into theoretical and conceptual ideas when little is known about a particular topic.

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[3] https://handbook.cochrane.org

There are a number of organisations that have produced robust guidance on the use of systematic methods for reviewing existing literature, such as the CC, the Centre for Reviews and Dissemination[4] (CRD), Evidence for Policy and Practice[5] (EPPI) and the Joanna Briggs Institute[6]. The CC are perhaps the best known for their detailed guidance on systematic review methods. Their purpose is to produce independent systematic reviews regarding the effectiveness of interventions within healthcare (Aveyard, 2014). Whereas the CC are considered by many as providing the 'gold standard' for conducting systematic reviews, Noyes (2010) identified the inherent emphasis on quantitative evidence, in particular, RCTs. More recently, the CC have recognised the importance of qualitative research in the synthesis of findings and have published guidance on how to incorporate qualitative research into a Cochrane review (Noyes et al., 2011). However, the notion that qualitative research merely complements the findings of any review with an RCT is still upheld. As I did not want to limit my review to research studies and given the lack of evidence surrounding the impact and outcome of children's and young people's involvement, I decided to follow the principles for systematic reviews set out by Gough, Oliver and Thomas (2012). They argue that all sources of evidence can help develop understanding and insight into a topic and that such evidence includes that from non-research sources.

This pragmatic approach to reviewing the literature involved incorporating methods from the guidance provided by the CRD (2009) and the principles set out by EPPI (Gough, Oliver & Thomas, 2012). This review was structured by adapting the steps recommended by the CRD (2009) for undertaking a review of the literature (Table 2.3), which support the inclusion of mixed research approaches to enable a synthesis of existing evidence. However, in keeping with arguments consistent with EPPI and the Joanna Briggs Institute, I have taken a novel approach by including literature described as projects and service evaluations. The reasons for this are discussed later in this chapter.

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[4] https://york.ac.uk/crd/
[5] http://eppi.ioe.ac.uk/cms/
[6] http://joannabriggs.org

2.4.1 Searching for evidence

Once the search question was formulated using the SPICE model, I was ready to start searching for evidence. The aim of the search was to identify all the relevant research pertinent to the search question, which included all published and unpublished or 'grey' literature. Grey literature is defined as being material that is not located ordinarily through bibliographic methods (Gray, 2014) and does not possess an International Standard Book Number (ISBN) or International Standard Serial Number (ISSN) (O'Leary, 2017). Examples of such literature include theses,

Table 2.3:   Eight-step approach to a literature review, adapted from the CRD (2009)

1. Developing the review question
2. Defining inclusion and exclusion criteria
3. Study design and selection of papers
4. Data extraction
5. Quality appraisal
6. Presentation of findings
7. Discussion and synthesis of findings
8. Summary from the literature review

dissertations, conference presentations, websites, newspaper articles and editorials. O'Leary (2017) suggests that recent theses and conference presentations can be a significant source of contemporary findings, whereas newspaper articles, brochures and leaflets can provide background and context. I commenced my search of peer-reviewed journals by accessing the appropriate health and social care databases. These included CINAHL and Medline (combined), PubMed, Internurse and the EPPI Information Centre, CRD, Joanna Briggs Institute, Education Resources Information Centre and Cochrane Database of Systematic Reviews. In turn, manual searches and reference list checking were also undertaken on the papers initially retrieved. Furthermore, grey literature was searched for using the British Library EThOS, the NMC and INVOLVE. These resources and databases were used because they

would provide a wide range of evidence pertinent to my literature search and research question.

2.4.2 Search terms

A variety of search terms were used, and the search strategy used was similar on all the databases, with some variations in the use of truncation, Boolean operators and wild cards. Boolean operators (AND/NOT/OR) and truncation (involv* and includ*) are used in order to enhance a search (Jesson, Matheson & Lacey, 2011). Words can be combined without using Boolean operators, but Offredy and Vickers (2010) suggest that this is not usually as efficient as using them. Wildcards are used when there are possible alternative spellings of words (Seale, 2012) and are often associated with differences between UK and US English spellings. A wild card was used for paediatric and pediatric.

The keywords used are listed in Table 2.4 and were combined in various configurations. I adopted an iterative approach to the development and identification of additional keywords, which is considered the most effective strategy for retrieving the maximum amount of relevant literature (Brettle & Grant, 2004).

Table 2.4:   Keywords organised according to the SPICE framework

Setting	**P**erspective	**I**ntervention
Higher education institution	Service user	**Simulation**
University	Child*	**Simulat***
HEI	Lecturer	**High fidelity simulation**
Education	Nursing student	**Clinical simulation**
College	Young people	Involvement
Undergraduate	Young person	Involv*
Institute	Teenage	Inclusion
Nurs*	Adolescent	Includ*
	Youth	Participation
	Service user and carer	Participate*
	Consumer	Coproduc*
	Customer	Coproduction
	P*ediatric	

The terms in bold were excluded from the stage 2 search.

2.4.3 Search limits

In keeping with guidance provided by Brettle and Grant (2004), limits were applied to the search to ensure efficiency. The date limit was set at 2000. Service user

involvement was a major focus of the NHS Plan (2000) and as noted in chapter 1, has since become increasingly prevalent within healthcare policy. In addition, service user involvement in nurse education was recognised in the NMC (2010) standards of education and since then has become integrated into many HEIs. I envisaged that limiting my search to 2000 would ensure that what was retrieved would reflect current healthcare policy and practice.

English language limits were also used. This was for pragmatic reasons, as I did not have the funding available to have papers translated. I recognised that this may have limited the findings from the literature to work published only in English.

2.4.4 Inclusion and exclusion criteria

Brettle and Grant (2004) recognise that the boundaries of a literature review must be defined by setting explicit inclusion and exclusion criteria. It is also fundamental to set these criteria so that the research questions can be addressed effectively (Gough, Oliver & Thomas, 2012). The inclusion and exclusion criteria used for this study are defined in Table 2.5.

Table 2.5:   Inclusion and exclusion criteria used for the literature search

Criterion	Inclusion	Exclusion
Date of publication	➢ Published between 2000 and 2018	➢ Published prior to 2000
Language	➢ Written in the English language	
Focus of publication	➢ Involvement in nurse education of people aged 25 years and younger ➢ Nursing programmes (all fields of practice) ➢ Papers from multiple perspectives (lecturers, CYP, parents, nursing students from all fields of practice)	➢ Other health and social care programmes (social work, physiotherapy and occupational therapy, for example) ➢ Studies that were solely concerned with the involvement of children and young people in practice (with no ref to higher education)
Study/project design	➢ Primary research papers ➢ Service evaluations and projects	

	➤ Unpublished theses ➤ Conference papers ➤ Editorials	

Inclusion

The age limit of the children and young people was significant, as the focus of the search question was on the involvement of young people in the education of CYP nursing students. However, owing to the specificity of this age group it was decided to include children in the search rather than focusing on young people alone. The age limit for the children and young people in the review was limited to 25 years and younger, which was in keeping with the AYPH's (2016) definition of what age constitutes being a young person. In turn, it is important to note that the nursing students were unlikely to care for children and young people over the age of 19 (unless there were exceptional circumstances), as most children and young people have been transferred to adult services by this age.

Papers that focused solely on the involvement of adults (most frequently referred to as service users) in the facilitation of simulation were excluded. In addition, any literature that centred on other health and social care programmes (as indicated in Table 2.5) and modules was excluded. For example, one study that was retrieved reported on the risks of being a voluntary standardised patient, but the students involved were medical rather than nursing students (Blake, Gusella, Greaven & Wakefield, 2006). Papers that addressed the involvement of children and young people in either practice or research alone were excluded, as the research question was centred on nurse education. In stage 2 of the search process one paper discussed a collaboration between lecturers and young people to determine what children and young people desired in terms of their mental wellbeing (Fallon, Warne, McAndrew & McLaughlin, 2012). Although this was informative, it was concerned more with participatory research and not participation in education; hence, this was excluded after the full paper had been retrieved.

2.4.5 Study/project design and selection of papers

In keeping with the CRD (2009) and EPPI (Gough, Oliver & Thomas, 2012) recommendations, the inclusion criteria should accommodate the study designs that

apply to the search question and provide the most data, as opposed to focusing on one specific design. This was important for this work, as I had determined to include all evidence, including non-research evidence. Therefore, I incorporated research approaches using qualitative, quantitative and mixed methods alongside service evaluations and projects into the search. Although no study was rejected if the quality of the work was questionable, the quality of all included papers is discussed critically in the sections that follow.

The papers were retrieved according to the guidance from the CRD (2009), which aims to minimise researcher bias. The selection process of studies included in the room is reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram (Moher, Liberati, Tetzlaff & Altman) (please see Figure 2.1). The initial electronic database searches yielded 536 results using combinations of the keywords. Firstly, the titles were scanned to assess which were applicable to the review question and 444 were excluded, leaving 92 titles. The abstracts of these were then screened for appropriateness and a further 84 were excluded, leaving eight papers. The full texts were then retrieved and read in full. Following this, six were excluded and only two papers were applicable to the search question (Austin, Hannafin & Nelson, 2013; Felton, Holliday, Ritchie, Longmack & Conquer, 2013). Austin et al. (2013) clearly highlighted the involvement of young people in a simulated disaster scenario. This research was conducted and published in the US, and therefore the undergraduate nursing students would not have been specifically training to be CYP nurses. However, as it evaluated the views of students about the inclusion of young people in simulation it was decided to retain this in the review. Figure 2.1 provides a PRISMA flow chart to illustrate the study selection

I recognised at this point that my search question was too specific and I needed to revisit it. As recognised by Aveyard (2014), a question that is too specific may lead to there being very little (if any) literature that can be included in the review. However, what was most important to me was the involvement of children and young people in simulation. Hence, the literature search was expanded to include children's nursing education and service user involvement. The search term 'simulation' was excluded from the subsequent search, with the focus of the intervention being 'involvement'. In turn, the search question was adapted to:

What are the views and perspectives of children and young people, undergraduate nursing students and university lecturers on the involvement of children and young people in nurse education?

Although I had spent a considerable amount of time on the first literature search, I had developed my searching skills and the subsequent search was not as time-consuming, as I was familiar and competent with the different databases and search strategies.

I followed the same screening process as I had used in the first search (see Figure 2.2). The main difference with this search was that the terms relating to simulation had been removed; the rest of the keywords were still used in various combinations. This search identified 903 hits. The titles of these articles were screened, which excluded 706 articles. A total of 197 abstracts were read, and 167 were excluded as they were not relevant to the search question. Following this, thirty full papers were retrieved and read, of which 17 were included in the review. Scrutinising reference lists of key articles is recommended by Aveyard (2014) and as a result a further two papers (Price, 2004 & Whittle et al., 2012) were retrieved, resulting in a total of 19 papers included in the review. The reasons for inclusion/exclusion are identified in Figures 2.1 and 2.2.

2.5 Data evaluation

The data evaluation stage in Whittemore and Knafl's (2005) framework dictates that the identified literature is ordered, coded, categorised and summarised. This process was initiated with evaluation of the data via the construction of a data extraction table. In keeping with Whittemore and Knafl (2005), a systematic analytic method was identified prior to commencing the review.

2.5.1 Data extraction

On the basis of the guidance from the CRD (2009), specific details were extracted from the 19 papers and are summarised in Table 2.6. The data extraction table distinguishes between research studies and service evaluations/projects. In keeping with the Health Research Authority (HRA, 2017), the papers identified as research studies had obtained institutional ethics approval. The headings in the table address various characteristics of the studies, including the aim of the study, sampling,

FIGURE 2.1 PRISMA FLOW DIAGRAM (STAGE 1)
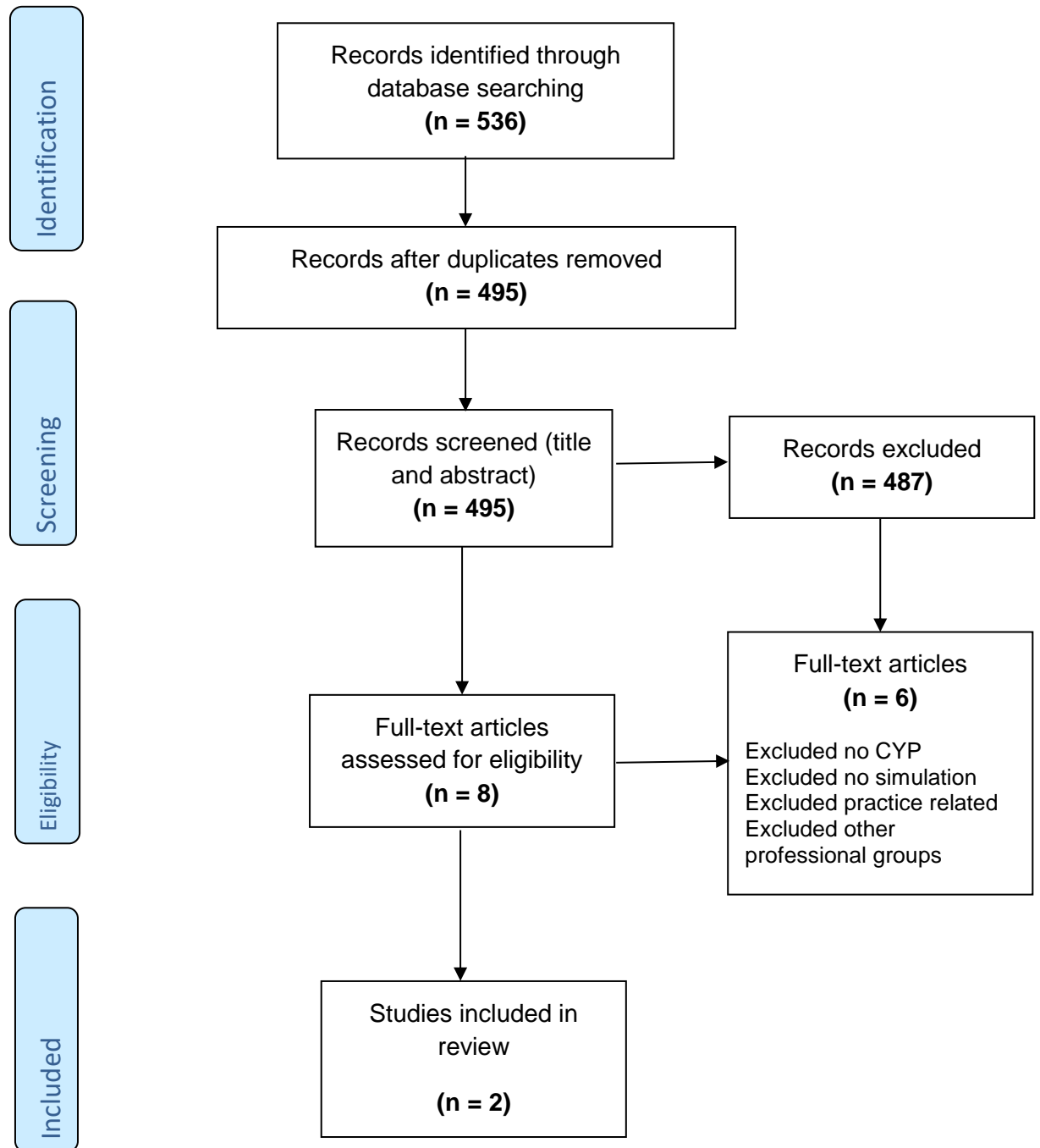
FIGURE 2.2 PRISMA FLOW DIAGRAM (STAGE 2)
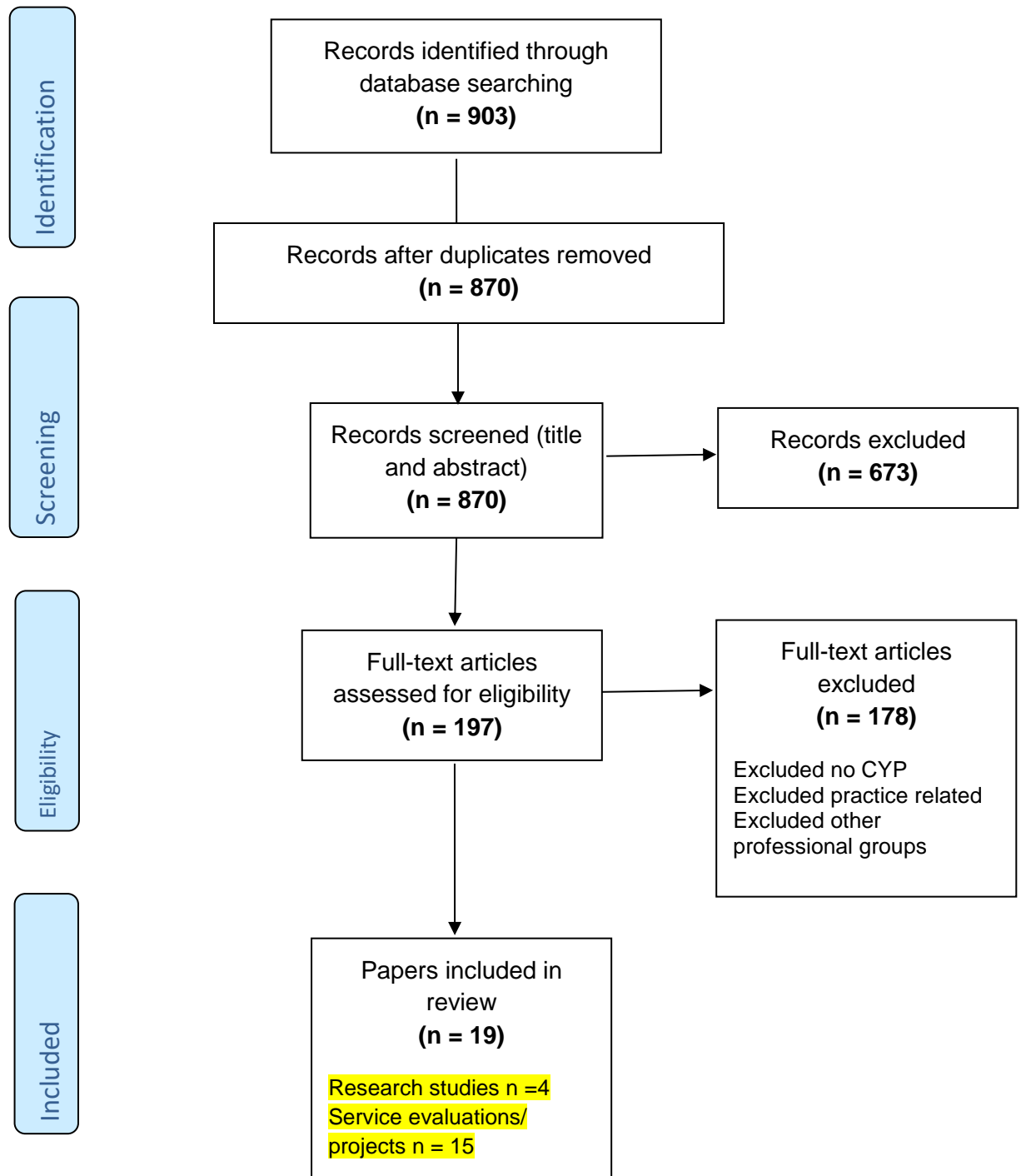
participant demographics, study design, data collection and findings. Each article was read and re-read thoroughly so that all the relevant information could be extracted and tabulated. This process ensured that I became very familiar with each aspect of the research process and findings that were reported. Aveyard (2014) has noted the importance of doing this in order to confirm the relevance of each piece of evidence to the study.

2.5.2 Quality appraisal

Following data extraction, each piece of evidence was then critically appraised using the Critical Appraisal Skills Programme (CASP UK, 2013) appraisal tools. Gough, Oliver and Thomas (2017) suggest that quality appraisal involves deciding whether the studies answer the review question and assessing the quality of the methodology. I recognised that the CASP tools are not designed for the appraisal of non-research papers, however given that the projects and service evaluations included aspects of the research process I was able to use some of the questions to help reach a decision about the overall quality of the body of evidence. That said, it is important to recognise that the use of a checklist or appraisal tool is not always fail-safe, as they are reliant on the information that has been published in the particular paper. Having an article published has some constraints, including word limits, journal style and the reviewers' and editors' preferences. In turn, Katrak, Bialocerkowski Massy-Westropp, Kumar and Grimmer (2004) conducted a systematic review of the content of systematic reviews. They found that there were a number of published critical appraisal tools, but many lacked specific information on how they were developed, and many were simply adapted from other tools. Although it has been argued that critical appraisal does not always help (Dixon-Woods et al., 2007), I found this to be a useful exercise to assess the rigour of the available evidence, and where appropriate used the questions in the checklist to establish the quality of the non-research included papers. This assisted in a systematic and consistent approach to the critical appraisal of each piece of evidence.

2.5.3 Geographical location and setting

The papers that I retrieved discussed studies or projects that had been conducted in universities, schools and healthcare institutions. With the exception of one (Austin et

al., 2013) conducted in the US, all the projects were conducted in the UK (see Table 2.6). Although the reasons for this are not yet clear and remain speculative, it is thought that this relates to the UK's leading role in public engagement and maybe the structure of CYP nursing as an entry-level qualification, a situation substantially different from that in most other countries.

2.5.4 Aim of the study/project

There were variations between each of the papers in terms of how they expressed the aim/purpose of their research/project, with seven of the papers failing to state a specific aim (Austin et al., 2013; Barnley, 2017; Carter & Brown, 2014; Price, 2004; Randall et al., 2008; Rouse & Torney, 2014; Sinclair et al., 2012) (see Table 2.7).

It seemed that the aims or focuses of the projects related to those who had been recruited to take part in the research or project. For example, in seven of the papers nursing students were asked their views about service user involvement in nurse education, and the aim/purpose of each paper centred on this (Austin et al., 2013; Fenton, 2014; Griffiths et al., 2012; Randall et al., 2008; Rhodes, 2013; Sinclair et al., 2012; Turnbull & Weeley, 2013).

Table 2.6:   Data extraction sheet

		RESEARCH STUDIES							
	Article/title	**Geographical location**	**Aim of the paper/study**	**Sample**	**Design**	**Ethics approval sought**	**Data collection**	**Analysis**	**Findings**
1	Austin, Hannafin and Nelson (2013) *Pediatric disaster simulation in graduate and undergraduate nursing education*	US	To provide a disaster simulation experience for nursing students	16 actors from a youth theatre (aged 6–15) 263 nursing students	Implies a Mixed methods approach – not explicitly stated	Yes	Questionnaires for nursing students Informal discussions with parents	Percentages provided by the answers to the Likert scale and ratings scale No method of analysis identified for parent discussion	Children were reported by their parents to enjoy being a simulated patient Nursing students reported increases in confidence, patient assessment and triage
2	Griffiths et al. (2012) *'A caring professional attitude': What service users and carers seek in graduate nurses and the challenge for educators*	UK	To discuss findings from a qualitative study about what qualities service users want in graduate nurses	52 service users and carers 6 women parents and 1 teenage son	Qualitative	Yes	Two-stage approach: conference to elicit views and focus group interviews	Interviews were recorded, transcribed and analysed using the framework approach	Service users seek technical competence, knowledge and willingness to seek information, but more a 'caring professional attitude'
3	Rhodes (2013)	UK	To investigate the impact of user involvement on	1 children's nurse (pre-	Qualitative: Narrative	Yes	In-depth narrative interviews collected on	Interviews were recorded, transcribed and	Participant clearly influenced by the experience of

	Service user involvement in pre-registration children's nursing education: The impact and influence on practice: A case study on the student perspective		student learning and practice	and post-qualification)	enquiry approach		completion of the 3-year programme and 1 year post-qualification	analysed using 'The Listening Guide'	user involvement – however, who were the users? **This is not specified and only alluded to**
4	Stevens et al. (2017) *Experiences of service users involved in recruitment for nursing courses: A phenomenological research study*	UK	To gain insight into service users' experiences of participating in recruitment for adult, mental health and CYP nursing studies	13 children and young people aged 13–17 years	Qualitative: Phenomenology	Yes	Focus groups with semi-structured interviews	Thematic analysis	A positive experience and meaningful involvement

<p align="center">SERVICE EVALUATIONS/PROJECTS</p>

	Article/title	Geographical location	Aim of the paper/study	Sample	Approach used	Ethics approval sought	Data collection	Analysis	Findings
5	Barnley (2017) *Service user involvement in pre-*	UK	To review the background and challenges of service user involvement in	17 CYP nursing students	Qualitative	No	Questionnaires with open-ended questions	No method of analysis is described.	Students reported that empathy, confidence and empowerment

	registration child nursing programmes			pre-registration children's nursing					States that evaluations were 'reviewed'	were important for service users Findings were very brief
6	Carter and Brown (2014) *Service user input in pre-registration children's nursing education*	UK		To discuss the successes and challenges of service user involvement in children's nursing	Suggests purposive sampling: 8-year-olds who had experienced inpatient care Members of two local Woodcraft groups (aged 9–12 and 12–16) Inpatient school room – voluntary survey	Indicates a qualitative approach	No	Focus group semi-structured interviews in primary school and Woodcraft groups Survey to trusts, school room and Woodcraft groups	Responses were recorded manually All data were analysed by the team and themes collated	All themes were consistent across groups Information gained helped formulate essay title for literacy screening and curriculum development and simulation scenarios Symposium did not recruit young people – used parents
7	Fallon et al. (2008) *'Pizza, patients and points of view': Involving young people in the design of a post registration module entitled the adolescent with cancer*	UK		To elicit the views of teenagers and young people with cancer in relation to the content of an 'adolescents with cancer' module	7 people aged 14–23 (4 male and 3 female)	Indicates a qualitative approach	Not stated, although states 'consent was gained..'	'Pizza, patients and points of view evening' Post-it notes and diamond ranking to establish the opinions of young people on teenage cancer care	Not stated but 'topics emerged' indicating a thematic approach	The module content was amended to include 'humour'
8	*Felton et al. (2013)*	UK		To design, implement and evaluate a shared learning experience	16 nursing students – at least 8 were	Qualitative approach indicated		Focus group and open-ended questionnaire	Thematic analysis	**Themes:** Simulation as a learning strategy

No	Author / Title	Country	Aim	Sample	Methodology		Data collection	Analysis	Findings
	Simulation: A shared learning experience for for child and mental health pre-registration nursing students		for child and mental health nursing students to develop skills for working with young people with emotional distress	children and young people					Learning with and from each other Areas for development
9	Felton, Cook and Anthony (2018) *Evaluating a co-facilitation approach to service user and carer involvement in undergraduate nurse education*	UK	To evaluate the effects of a co-facilitation approach on nursing students' classroom learning	198 total (adult, mental health, CYP student nurses) Breakdown of CYP not included, but <25	Qualitative approach	No	Questionnaires with open-ended questions	Thematic analysis using Braun and Clarke (2006)	**Themes:** Learning approach and meeting learning objectives Theory and practice links Communication skills Values
10	Fenton (2014) *Involving a young person in the development of a digital resource in nurse education*	UK	To outline a project that developed a digital learning object based on the experiences of a young person with cancer	40 students	Mixed methods approach adopted	No	Questionnaire adapted from a learning object review instrument Questions – 8 statements and 3 possible responses (agree, neither, disagree). Free text additional comments box	Not stated	Maya (the young person) reported the experience as 'cathartic and enjoyable' Over 80% of the students found the digital learning object interesting and were motivated to explore its content – positive responses about

									listing to a patient's journey
11	Fletcher et al. (2011) *Building the future: children's views on nurses and hospital care*	UK	To reflect the involvement of child and young person users in the development of a new undergraduate children's nursing programme curriculum and in service developments	40 children and young people	Qualitative approach adopted	No	'Draw and write/draw and tell'	Riley's (1996) technique of coding data thematically	Future children's nurses to be skilled in both verbal and non-verbal communication and clinical skills. Children admitted to hospital may be scared and have a fear of the unknown Results of this would inform future curricula
12	Price (2004) *A parent in the classroom – a valuable way of fostering deep learning for the children's nursing student*	UK	To study the value of a parent in the classroom in fostering deep learning in children's nursing students	35 children's nursing students	Qualitative approach: Action research	No	Questionnaire, peer observation and reflective diary	Data collection tool designed to capture both qualitative and quantitative data Results were read, re-read and themed	Very positive experience for the students
13	Randall, Brook and Stammers (2008) *How to make good children's nurses: children's views*	UK	To seek the views of children to inform a new curriculum about how to make good children's nurses	A purposive snowball sample of 10 children who were receiving or had received nursing care (4 boys, 6 girls)	Qualitative approach adopted	No	Children were given body outlines to complete on 'good' and 'not so good' nurses as a prompt for semi-structured one-to-one interviews, and field notes	Field notes from research team were brought together and analysed using a thematic approach	Children's nurses are both born and made. 3 main themes that could be integrated into a curriculum: 'professional persona, attitudinal

				(NO AGE)			were taken by the bedside (NOT RECORDED)		learning/personal qualities, and experiential, cognitive and psychomotor learning'
14	Randall and Hill (2012) *Consulting children and young people on what makes a good nurse*	UK		To involve children in the development of nursing curricula and find a way that is more than a one-off consultation	11 children (11–14 years old)	Qualitative approach adopted		6 sessions exploring what makes a good and not so good nurse Notes taken by researchers during each of the sessions	Although specified as a log, the data appear to have been collated into themes, representing thematic analysis	The children's comments and suggestions have been taken into account in redesigning the curricula (though not yet implemented)
15	Rouse and Torney (2014) *Service user and carer involvement in pre-registration student selection*	UK		To evaluate the process of involving service users and carers in student recruitment	8 service users and carers from the 'Impact' team (assume adults) 21 Lecturers 22 practitioners 138 candidates	Mixed methods approach adopted	No	An online questionnaire was distributed Likert scale with 5 points. 22 questions and free text questions	Percentages provided by the answers to the Likert scale, and the free text comments were organised into themes **Responses**: 4 service users 5 practitioners 13 lecturers 34 students (3 children's nursing)	Service users can benefit the recruitment and selection process; however, concerns were raised about how and when service user involvement should occur
16	Sinclair, Camps and Bibi (2012) *Looking after children and young people:*	UK		To highlight the importance of collaborating with looked after children and young people to inform the nursing curriculum	Unknown number of young people and social work team Group of BSc in Children's	Qualitative approach adopted: Reflective commentary	No	Two reflections from students	No data analysis	Feedback from two students was gained, and clearly a good learning experience

	Ensuring their voices are heard in the pre-registration nursing curriculum				Nursing students				
17	Summers (2013) *Children's nurse education – what is important to the service user?*	UK	To establish the views of children and young people about what knowledge, skills and attributes future children's nurses should possess	Purposive (chosen from total population of a children's hospice) Number of participants not specified	Qualitative approach	No	Focus group interviews – not stated how many	"Data collated were reviewed using descriptive and thematic forms of analysis"	What mattered most to the young people were communication and making time to listen, access to mainstream education, transition to adult services and going clubbing These have been integrated into the programme
18	Turnbull and Weeley (2013) *Service user involvement: Inspiring student nurses to make a difference to patient care*	UK	To evaluate an innovation regarding a student nurse pledge after some exposure to a service user story	284 pledges by pre-registration nurses (all fields of pratice 15 CYP nursing students	Qualitative approach adopted	No	4 modules identified for service user involvement All participants completed a voluntary evaluation and 278 reported that it had enhanced their understanding of the module	Not stated	Of the 15 CYP nursing students, 10 fulfilled their pledge
19	Whittle, Lonsdale and Bimson (2012)	UK	To involve young people in the recruitment of CYP nurses	26 school students aged 13–15	Discussion paper	No	Not stated, although some data collected	Not stated	One paragraph in article – very limited. Candidates' views

	Involving school students in selecting candidates for children's nursing					from the candidates		on input of children and young people = 'scary, but helpful'; some intimidated and uneasy

Table 2.7:   Aim/purpose of the study or project

PAPER NO:	AUTHOR(S)	PURPOSE/AIM – explicit YES/NO
1	Austin et al. (2013)	No – stated in the paper that the aim was to provide a disaster simulation experience for nursing students
2	Griffiths et al. (2012)	Yes "To involve users and carers in the development and delivery of curricula in the School of Nursing Midwifery and Social Work" (p. 122) However, this aim was part of a larger project and therefore seems quite vague
3	Rhodes (2013)	Yes (two aims) "To demonstrate the value of involving a parent in teaching children's nursing" and "Conducting an in-depth investigation into the impact of user involvement on student learning and practice" (p. 292)
4	Stevens et al. (2017)	Yes "To identify the lived experiences of service users involved in recruitment to nursing courses" (p. 62)
5	Barnley (2017)	No aim stated
6	Carter and Brown (2014)	No – difficult to interpret the overall aim of the project; however, the aim of the paper was described as discussing the challenges of service user involvement in children's nursing
7	Fallon et al. (2008)	Yes "To elicit teenagers and young people with cancer views in relation to the content of an 'adolescents with cancer' module" (p. 143)
8	Felton et al. (2013)	Yes "To design, implement and evaluate a shared-learning experience for pre-registration child and mental health branch nursing students in a UK University to develop their skills for working with young people who experience emotional distress" (p. 536)
9	Felton et al. (2018)	Yes "To evaluate the effects of a co-facilitation approach on nursing students' classroom learning" (p. 49)
10	Fenton (2014)	Yes "To develop and embed a digital learning object within taught modules in order to expose students to the lived experience of a young person with a life-threatening condition and evaluate students' perceptions of this as a teaching and learning tool"
11	Fletcher et al. (2011)	Yes "The primary aim of the study was to reflect child and young person user involvement in the development of a new undergraduate children's nursing programme curriculum and in service developments for two discrete children's hospitals in the south of England" (p. 40)

12	Price (2004)	No However, it states that "My study examined the value of a parent in the classroom in fostering deep learning in children's nursing students" (p. 6)
13	Randall et al. (2008)	No – difficult to ascertain. In the abstract it is stated that: "A consultation was held to seek children's views on how to make better children's nurses to influence a new curriculum" (p. 22)
14	Randall and Hill (2012)	Yes "To find a way that was more than a one-off consultation to involve children in nursing curriculum development" (p. 14)
15	Rouse and Torney (2014)	No However, in the abstract it is stated that: "An online questionnaire was undertaken to evaluate the involvement of service users and carers in the student selection process and to identify how the pre-registration process might be enhanced" (p. 37)
16	Sinclair et al. (2012)	No aim stated
17	Summers (2013)	Yes "To elicit children's and young people's views about the knowledge, skills and attributes they considered future children's nurses should possess, centred on the lived experiences of the children and young people from the hospice" (p. 748)
18	Turnbull and Weeley (2013)	Yes "To support health care students to gain insight of health care from the service user perspective and to enhance patient care"
19	Whittle et al. (2012)	Yes "Increasing the numbers of young people from disadvantaged backgrounds in higher education by working with schools, further education colleges and universities" (p. 34)

2.5.5 Sample

As I was interested in multiple perspectives (young people, students and lecturers), I found it useful to identify and present a summary of the samples recruited (Table 2.8). The groups of participants included nursing students, children and young people, lecturers and adult service users. In total, from all the studies included in the review data were reported from148 CYP nursing students, 68 children and young people and 13 lecturers.

Table 2.8:   Sample

AUTHOR(S)	SAMPLE		Children and young people	Adult service users	Lecturers
	Nursing students				
Austin et al. (2013)	263 (field unknown)				
Barnley (2017)	17 (all CYP field)				
Carter and Brown (2014)			Not stated		
Fallon et al. (2008)			7 (14–23 yrs)		
Felton et al. (2013)	16 (MH and CYP fields) CYP est. 10				
Felton et al. (2018)	198 (CYP est. 25)				
Fenton (2014)	40 (all CYP field)				
Fletcher et al. (2011)			Not stated		
Griffiths et al. (2012)			1 (male, teenager)	51	
Price (2004)	35 (all CYP field)			1 (parent of a child)	
Randall et al. (2008)			10		
Randall & Hill (2012)			11		
Rhodes (2013)	1 (CYP field)				
Rouse and Torney (2014)	34 (3 CYP field)			4	13
Sinclair et al. (2012)	2 CYP field				
Stevens et al. (2017)			13		
Summers (2013)			Not stated		
Turnbull and Weeley (2013)	284 (15 CYP field)				
Whittle et al. (2012)			26		
TOTALS	CYP Field **148**	Other 742	**68**	**56**	**13**

One paper included the views of five practitioners (Rouse & Torney, 2014). The sampling method was stated clearly in three papers (Randall et al., 2008; Rhodes, 2013; Summers, 2013), with all using a purposive approach. However, these sampling methods could also be described as convenient and in some cases self-selected. This presents a challenge to the quality of the evidence. Moreover, 16 studies did not clarify their sampling method (Austin et al., 2013; Barnley, 2017; Carter & Brown, 2014; Fallon et al., 2008; Felton et al., 2013, 2018; Fenton, 2014; Fletcher et al., 2011; Griffiths et al., 2012; Price, 2004; Randall & Hill, 2012; Rouse & Torney, 2014; Sinclair et al., 2012; Stevens et al., 2017; Turnbull & Weeley, 2013; Whittle et al., 2012). However, six papers suggest purposive sampling, as nursing

students were recruited from a specific cohort of students (Barnley, 2017; Felton et al., 2013, 2018; Fenton, 2014; Price, 2004; Stevens et al., 2017). Fletcher et al. (2011) did not specify in the methods section how participants were sampled but stated in the conclusion that the findings were limited owing to the small convenience sample. In combination, the small sample sizes and the means of recruitment into the studies and projects further limit the quality of the evidence and mean that any findings must be treated with caution.

2.5.6 Sample – Nursing students

The studies reviewed varied considerably in sample size from one nursing student (Rhodes, 2013) to 263 nursing students (Austin et al., 2013). Whereas Mason (2002) suggests that a sample size of one is possible in qualitative work such as life history or case study research, it is usually associated with in-depth and repeated research encounters. Rhodes (2013) conducted an in-depth investigation into how service user involvement had an impact on the learning and practice of one student nurse. Rhodes (2013) indicates that this student was specifically chosen as she had been affected personally by one specific experience of service user involvement and wanted to explore this further herself. It is therefore possible that she self-selected rather than being recruited. This means, as noted by Rhodes (2013), that the results are not generalisable; that said, it is possible that for some the nature of the interview with the student will have resonance with other student perspectives. This means that the findings are interesting, although much more research into this is needed. Similarly, Sinclair et al. (2012) had a sample size of two CYP nursing students who could have self-selected for involvement in the project.

Some of the papers clearly stated the sample size in relation to the field of nursing practice. Barnley (2017) recruited a sample of 17 CYP nursing students, whereas a more substantial sample size (40) was used in Fenton's (2014) project.

Fenton (2014) discussed how a young person helped develop a DLO and embed it within taught modules of the undergraduate nursing programme. Similarly, Price (2004) examined the value of involving a parent in the classroom, and the sample size (35) was similar to that in Fenton's (2014) project. Barnley (2017), Fenton (2014), Price (2004), Sinclair et al. (2012) and Rhodes (2013) collected data from CYP nursing students alone, whereas Felton et al. (2013), Felton et al. (2018),

Turnbull and Weeley (2013) and Rouse and Torney (2014) reported on data collected from adult, mental health and CYP nursing students. The findings in these studies are presented as a whole and do not distinguish between the different fields of practice. Thus, the numbers of CYP nursing student participants are unclear. In Austin et al.'s (2013) publication the speciality of the nursing students is not reported; however, it is noted that as this was a US study with undergraduates they will all have been general nurses, as nurse training is only field-specific post-registration. One paper included the views of undergraduate nursing students (Rouse & Torney, 2014) who had been successful at interview and were enrolled on the BSc Nursing programme. However, it is interesting to note that those who were not successful at interview were not included in the sample.

2.5.7 Sample – Children and young people

Of the 19 reviewed studies, nine included children and young people in the sample (Carter & Brown, 2014; Fallon et al., 2008; Fletcher et al., 2011; Griffiths et al., 2012; Randall et al., 2008; Randall & Hill, 2012; Stevens et al., 2017; Summers, 2013; Whittle et al., 2012). Among all these papers the total sample of children and young people was 68, of whom 26 participated in the study conducted by Whittle et al. (2012). The age range was 8–23 years. However, in three of the papers the sample size and age range of participants were not specified (Carter & Brown, 2014; Fletcher et al., 2011; Summers, 2013), although it is acknowledged that they were children and young people. Three of the papers (Fallon et al., 2008; Griffiths et al., 2012; Randall et al., 2008) specifically identified the gender of the sample, whereas the other six did not. Although it is interesting to state the total numbers, it is acknowledged that it is not possible to aggregate the samples in any meaningful way.

With the exception of Whittle et al. (2012), all the samples included children and young people who were receiving or had received treatment in a hospital.. That said, Whittle et al. (2012) recognised that those in their sample all reported having received some form of healthcare treatment, including going to see their GP or involvement in a vaccination programme. More significantly, Whittle et al,'s (2012) work helped me to understand that most young people will have experienced some

aspect of healthcare and that it was necessary for my study to consider including those who had not experienced hospitalisation.

2.5.8 Sample – Lecturers

Only one of the papers included lecturers or academic staff within the sample. Rouse and Torney (2014) invited 21 lecturers via email to complete an online questionnaire about the involvement of service users in the recruitment of nursing students. The response rate was 13 (62%), and sample characteristics were not collected in order to ensure anonymity.

2.5.9 Study design

Of the 19 papers reviewed, four were identified as research studies (Austin et al, 2013; Griffiths et al., 2012; Rhodes, 2013; Stevens et al., 2017) (see Table 2.6). One of the studies (Austin et al, 2013) used a mixed methods approach, whereas the remaining three used a qualitative approach. 15 papers were identified as service evaluations/consultations or projects (see table 2.6). These papers had not gained institutional ethics approval yet aspects of the research methods were evident in all. Fenton (2014) and Rouse and Torney (2014) used a mixed methods approach and the remaining 13 papers used a qualitative approach to the evaluation/project.

2.5.10 Data collection

Depending on the nature of the paper, the method used to collect and analyse data varied considerably and was not always stated explicitly. Table 2.9 summarises the methods of data collection and the processes used for data analysis. Although only five of the studies claimed to be research studies (Griffiths et al., 2012; Price, 2004; Rhodes, 2013; Stevens et al., 2017; Summers, 2013), the remaining studies (except for Whittle et al., 2012) all discussed some form of data collection. Six of the studies used interviews (including one-to-one and focus groups) to collect data (Felton et al., 2013; Griffiths et al., 2012; Randall et al., 2008; Rhodes, 2013; Stevens et al., 2017; Summers, 2013).

Griffiths et al. (2012) used broad questions that were based on previous work in this field by Rudman (1996) and asked service users what qualities they thought nurses should possess. The participants were also asked questions about how they would

choose to be involved in the planning and development of a nursing curriculum. It was stated that the facilitators of the focus group interviews were experienced qualitative researchers. In a similar way to Griffiths et al. (2012), Summers (2013) used focus group interviews with children from a local hospice to ascertain what qualities, skills and attributes they thought future nurses should possess. Summers (2013) stated that a number of focus groups were conducted; however, it is not clear exactly how many were conducted and how many participants were included in each one.

Two studies used questionnaires with open-ended questions (Barnley, 2017; Felton et al., 2018) and, despite the involvement of service users in their projects, data were collected from nursing students only.

Two studies used innovative and child-friendly approaches to collecting data involving the use of drawings (Fletcher et al., 2011; Randall et al., 2008). Randall et al. (2008) sought the views of ten children on the qualities that make a good nurse. Body outlines were provided to children to prompt them in the semi-structured interviews. Randall et al. (2008) state that comprehensive field notes were taken during the interviews, which they recognised may have introduced bias as only the interesting parts of the data may have been noted. During the interviews with the children, Randall et al. (2008) recognised that some questions were confusing the children, and they were adapted. Perhaps some initial preparation with the children would have reduced the need for this.

Like the body outline drawings used by Randall et al. (2008), Fletcher et al. (2011) used the 'draw and write/draw and tell' technique to seek the views of children and young people, which Mauthner (1997) states is a good method if children are unable to understand the research topic. Fletcher et al. (2011) provide a detailed critique and a rationale for choosing this method of data collection.

Randall and Hill (2011) used the personal, social, health, and economic education and citizenship (PSHEE/citizenship) school session with hospitalised children to find out what children thought about makes a good nurse. They stated that the data collection needed to be flexible. A teacher led the sessions and a nurse educator was present to add context to the discussions and make notes on the children's

responses. There were six sessions in total and Randall and Hill (2011) included a table which outlines the main areas for discussion.

Rhodes (2013) conducted two in-depth narrative interviews with the one student nurse participant in her study to examine the impact of user involvement on student learning and practice. One interview was conducted at the time of completion of the participant's nursing programme, and the subsequent interview was conducted one year post-registration. Rhodes (2013) points out that the interviews were structured using a small number of questions to provide a loose structure without detracting from the purpose of narrative research.

Four of the papers describe a mixed methods approach to data collection (Carter & Brown, 2014; Fenton, 2014; Price, 2004; Rouse & Torney, 2014). Rouse and Torney (2014) evaluated the benefit of involving service users and carers in pre-registration student selection. Eight service users and carers were recruited to participate in the recruitment of student nurses; this was in the group activity stage of the interview process only. This included interviewing students for all fields of practice (adult, mental health and children's nursing). Rouse and Torney (2014) used an online questionnaire to evaluate the process, and all those involved in the interview days were asked to complete this (lecturers, practitioners, service users and applicants). The Bristol Online Survey Program was used with a five-point Likert scale for responses ('strongly agree' to 'strongly disagree' and an option to select 'not applicable'). All questions allowed free text comments. Response rates varied amongst the groups: 25% applicants, 62% lecturers, 50% service users and carers, 23% practitioners. Rouse and Torney (2014) speculate on possible reasons for the low response rates, concluding that it was so low amongst the applicants because they had already been notified regarding whether they had been offered a place on the programme. Rouse and Torney go on to recognise that this may have introduced an element of bias, as the results of their questionnaires may have been based on the successful outcomes of their interviews rather than on the process itself. However, they fail to discuss their view on the reason for the very low response rate from practitioners.

Carter and Brown (2014) interviewed children in small groups at school using semi-structured interviews. The interviews were conducted by members of the child health

team and the responses were recorded manually. It is not clear whether hand written notes were taken were and this could have biased the data if only certain information was recorded. Surveys were also distributed as part of the data collection, although it is not clear whether the survey used quantitative or qualitative questions.

Fenton (2014) used a questionnaire adapted from a learning object review instrument (LORI) (Leacock & Nesbit, 2007). The questionnaire consisted of eight statements referring to perceptions of the digital learning object (DLO) with three responses possible: agree, disagree or neutral. An open-ended question was also included to enable the nursing students to add comments about the DLO. The questionnaire was distributed to and completed by all the students (n=40).

Price (2004) used questionnaires to collect quantitative and qualitative data. The data from the questionnaires were analysed by correlating the number of yes/no responses to the questions posed.

Austin et al. (2013) do not state how the authors collected the data from the parents, although it is implied that there was a discussion. Student nurses completed questionnaires to evaluate their confidence and knowledge gained by undertaking the paediatric disaster simulation. It is stated that students were also interviewed by film crews, but the results from this were not published. Students were asked to report their confidence levels on a scale of 0–4, where 0 represented no confidence and 4 represented absolute confidence. However, the validity and reliability of this scale is not reported.

Four of the papers did not include any discussion regarding data collection or analysis methods (Fallon et al, 2008; Sinclair et al., 2012; Turnbull & Weeley, 2013; Whittle et al., 2012), although all were described as projects. Sinclair et al. (2012) discussed how two students reflected on a session given by 'looked-after' children and gave some background to the discussion. Similarly, Whittle et al. (2012) discussed their project about involving 13–15-year-olds in the recruitment and selection of CYP nursing students; however, no clear data collection or analysis is reported.

Turnbull and Weeley (2013) discuss the evaluation of a project that involved student nurses making a pledge to service users after they had listened to a patient's story

in the classroom. The authors provide a paragraph on the students' evaluations from the session, but the main focus of the paper is about the success of the pledge that they had made as a result of the session. The nursing students were required to take this pledge into practice with them, and their mentor was required to verify whether they had achieved this pledge.

Fallon et al. (2008) took a different approach by concentrating on using engagement strategies to help the young participants in the study reveal their thoughts and opinions. There is no discussion regarding data collection or analysis, rather they used engagement strategies from a Participation Works toolkit (Shephard & Treseder, 2002) to aid the young people's participation and provide a framework for the evening. The activities used were the 'Post-it ideas storm' (p. 48), 'diamond ranking' (p. 70) and 'dot voting' (p. 58), which was used to help the young people identify individual priorities from the diamond ranking exercise. These strategies proved very successful, and I used diamond ranking in my study, which is explored further in chapter 4.

2.5.11 Data analysis

Summers (2013) reviewed and reported the data using descriptive and thematic analysis. Whilst Summers (2013) does not provide further details regarding data analysis or which thematic framework was used, Griffiths et al (2012) stated that the data was transcribed verbatim and analysed using the framework approach (Ritchie & Spencer, 1994). Further, Griffiths et al (2012) identify that the analysis was carried out by all members of the research team and they met to discuss the differences and similarities with their coding and themes. In turn, the rigour of the coding process was assessed by feeding back the codes and themes to the service users.

Barnley (2017) states that the questionnaires use in this study were reviewed and does not specify how the data was analysed. However, Felton et al (2018) reports that the data from the questionnaires was analysed using the thematic framework in accordance with Braun and Clarke (2006). Similarly, Rouse and Torney (2014) report the results of the Likert scale questionnaire as response frequencies and percentages and state that the free text responses were organised into themes; however, they do not identify if a specific framework was used for data analysis. Carter and Brown (2014) state that the data was analysed to identify themes and

mapped across the different data sets, however it is not stated whether a specific thematic framework was applied to the analysis.

Randall et al (2008) state that the field notes from the consultation team were collated and a thematic approach was adopted to analyse the data.. In addition, they identify that members of the research team and postgraduate children's nursing students used Riley's (1996) method for analysing data with coloured highlight pens to identify common themes.

Randall and Hill (2011) used the notes from the school sessions to construct a log. The data from the logs and images created by the children was analysed by reading and re-reading the text, identifying codes and using axial coding (Parahoo, 2006). However, it is not stated who and how many people undertook the data analysis.

In keeping with Doucet and Mauthner (2008), Rhodes (2013) adopted the 'listening guide' approach to data analysis, in which the transcripts are read several times, but each time with a focus on a different approach. For example, the first reading involves listening for the plot and, in keeping with Randall et al. (2008), recognising researcher reflexivity. Rhodes (2013) is reflexive in her approach to data analysis, recognising that her extensive experience of service user involvement in education may have had an effect on the subjective interpretation of the data collected. It seems that some of those involved in this work valued what reflexive practice brought to their work.

The results from the questionnaires were reported using descriptive statistics. Fenton (2014) states that the free text comments were groups thematically but does not identify if a recognised published thematic framework was used. Although Fenton (2014) states that the questionnaire had been adapted from a LORI, there is no discussion about whether the questionnaire had been reviewed by anyone else, nor any discussion relating to the validity and reliability of the instrument or how Fenton's adaptations may have had an impact on these. This means that the results, albeit interesting, should be treated with caution. Price (2004) explained that all the qualitative data were read through several times and that recurring themes emerged. This is similar to the way that data analysis was approached by Fenton (2014), but again a specific framework is not referred to. The author wrote a reflective diary and had coffee with the parent to discuss her experience of speaking to the students;

however, it is not noted whether this was recorded or if notes were taken. Austin et al (2013) also reported the findings using descriptive statistics, reporting that 52% of the students reported some confidence, 21% stated they were very confident, 19% reported that they were slightly more confident than previous to the exercise and 42% of the students reported that the exercise was fast paced, and they needed to remain calm.

Table 2.9:   Summary of data collection and analysis

PAPER	AUTHOR(S)	DATA COLLECTION	DATA ANALYSIS
1	Austin et al. (2013)	Likert scale 0–4	Not clear – some results expressed as percentages
2	Griffiths et al. (2012)	Focus group interviews	Transcribed verbatim and analysed using the framework approach (Ritchie & Spencer, 1994)
3	Rhodes (2013)	In-depth narrative interview	Transcribed verbatim and analysed using the 'Listening Guide' (Doucet & Mauthner, 2008)
4	Stevens et al. (2017)	Focus group interview	Thematic analysis (Braun & Clarke, 2006)
5	Barnley (2017)	Evaluation with open-ended questions	Not stated
6	Carter and Brown (2014)	Focus group interviews (responses recorded manually) and surveys	Data analysed and themes identified. No explicit framework referred to, but suggestive of a thematic approach
7	Fallon et al. (2008)	Post-it notes and diamond ranking	Authors state 'topics emerged', indicating a thematic approach
8	Felton et al. (2013)	Focus groups pre- and post-simulation. Questionnaire with open-ended questions	Thematic analysis
9	Felton et al. (2018)	Questionnaire with open-ended questions	Braun and Clarke (2006) thematic analysis
10	Fenton (2014)	Questionnaire – (agree/neither/disagree responses) with one open-ended question	Results of quantitative data were expressed as percentages. Written comments were grouped into themes (no specific framework referred to)
11	Fletcher et al. (2011)	'Draw and write/draw and tell'	Thematic (Riley, 1996)

12	Price (2004)	Questionnaire – Yes/No responses with free text responses	Quantitative – YES/NO reported as a percentage Qualitative – not explicit but suggests a thematic approach
13	Randall et al. (2008)	Semi-structured one-to-one interviews PLUS field notes	Thematic approach
14	Randall and Hill (2012)	Field notes taken by researcher and drawings/text written by children	Not specified but the data are presented in themes, indicating a thematic approach
15	Rouse and Torney (2014)	Online questionnaire using 5-point Likert scale and free text responses	Results expressed as response frequencies and percentages Free text – organised into themes, no specific framework stated
16	Sinclair et al. (2012)	Reflective written commentary with 2 students	None stated
17	Summers (2013)	Focus group interview	Descriptive and thematic analysis
18	Turnbull and Weeley (2013)	Not specified	Not specified
19	Whittle et al. (2012)	No obvious data collected, describes a project	No data analysis

2.7.10 Summary of quality appraisal

Interestingly, although policy and practice guidance advocates for the inclusion of children and young people in all aspects of healthcare, including education, as discussed in Chapter 1, there is a paucity of evidence regarding the benefits, outcome or impact of such involvement. The appraisal of the studies discussed hitherto indicates that there is limited evidence, with most being of poor quality. Quality can be hampered by recruitment strategies, a lack of robust data collection instruments and poorly described analysis. In some work, assumptions regarding who can speak on behalf of children and young people are questionable, with parents being used as the 'proxy voice' of their children. However, children and young people often express different views from those of their parents and adult carers. Few studies included in this review explored subjective insights from the perspective of the children and young people involved, and there remains a lack of insight regarding the benefits or drawbacks of involving children and young people in nurse education. That said, it is worth collating the findings to produce a synthesis of the current evidence; although this is weak, some insight can be gleaned from what does exist.

2.6   Presentation of findings

According to Whittemore and Knafl (2005), the data analysis stage of an integrative review concerns an iterative approach of identifying patterns, themes and relationships within the literature. This was achieved through reading and re-reading the papers and identifying and coding themes/patterns in an iterative manner. In this section, the themes identified from the literature review will be critically explored. Following this, a critical discussion of the findings from the review will be presented.

In one way or another, all the papers included in this review address the benefits and/or drawbacks of involving adult, child and young person service users in the education of CYP nursing students or the processes used in their recruitment and selection. The findings or discussions within the papers are largely in agreement with each other, namely, that there are clear benefits to service user involvement in the education of CYP nursing students, which were categorised as follows:

- Outcome and impact of service user involvement on the learning of CYP nursing students

- Children's and young people's involvement in curriculum design

- Service user involvement in the recruitment and selection of nursing students

- The impact of service user involvement on practice

2.6.1   Outcome and impact of service user involvement on the learning of CYP nursing students

Here, the findings that are presented concern how the involvement of service users had a positive impact on the learning of nursing students. Six of the papers included in the review reported findings on the effects that involving a service user in the classroom teaching of CYP nursing students had on their learning and on themselves (Barnley, 2017; Felton et al., 2018; Fenton, 2014; Price, 2004; Rhodes, 2013; Sinclair et al., 2012). However, two of these studies (Price, 2004; Rhodes, 2013) included the involvement of a parent in the classroom rather than children and young people. Despite this, the participants in these studies reported positive impacts that followed these sessions regarding the effect that listening to a parent had on their learning and development as CYP nursing students.

In Rhodes's (2013) study, one of the key findings reported is that of authenticity. Anna (the pseudonym used for the participant) identifies that listening to a parent in the classroom helped her to learn about something that cannot be learned from a lecture. Rhodes (2013) identifies that the comments from Anna made her consider the issue relating to authenticity and how service user involvement assists in making a situation more 'real' for the student. Moreover, Rhodes (2013) suggests that there are positive outcomes that result from exposing students to an upsetting experience in university, as opposed to experiencing this for the first time in practice. This fits well with a key component of the ethos underpinning simulation, namely, that of learning in a safe environment.

Fenton (2014) reported results relating to the outcome and impact of involving a young service user in the production of a DLO. The DLO was a digital video recording of the young person describing her experiences of being a patient with a life-threatening condition. Although there was a high level of agreement that the use of a DLO resource developed by young service users was of benefit, not all students agreed, yet the reasons for this remain uncertain. The first question identified in Fenton's work (2014) relates to the concept of listening to service users' stories and how they provide students with 'insight' into what it feels like to be a patient. 'Insight' is a word that is also identified within Rhodes's (2013) study. Although a notion regarding insight is apparent in both papers, the service user and carer providing this input differ, one being the young person (service user) and the other being the parent (carer). Thirty-three of the 40 students who completed the questionnaire in Fenton's study (2014) stated that they agreed that the DLO had provided them with insight. No reasons are provided as to why the remaining seven nursing students did not agree with this statement. The second question in the work by Fenton (2014) concerned how the DLO had helped the nursing students to understand the patient's experience of healthcare. The findings suggested that the resource was beneficial for understanding more about the patient journey and experience.

Price (2004) reported that 100% of the students felt that the involvement of a parent enhanced their learning and that it would be beneficial to involve parents in other taught sessions. Fenton (2014) and Price (2004) did not collect data on the emotional responses of the students involved in their projects. Conversely, the data collection methods used by Rhodes (2013) enabled insight into such emotional responses.

Rhodes's participant explained that she had anticipated being upset by listening to the journey of a teenager diagnosed with cancer; she stated that she was "distraught" and was surprised by her reaction. It seems that there is a balance to be struck between depth and breadth in research studies.

'Reality', 'insight' and 'viewing a situation through a parent's eyes' were found to be common themes reported by Fenton (2014), Price (2004) and Rhodes (2013). Although Fenton (2014) and Price (2004) appear to have focused more on the 'learning' that is gained from engaging with a parent or young person in the classroom, Rhodes (2013) examines not only the learning but also the effect that this had on the personal and emotional feelings of the student.

Sinclair et al. (2012) also considers the professional and personal impact that listening to the experiences of two young people had on the development of two nursing students. The reflective commentaries from the two nursing students clearly indicate that it had an impact on their personal and professional development, which resonates with the students' experiences in the studies discussed earlier (Fenton, 2014; Price, 2004; Rhodes, 2013). Of note are the participant reports of the sessions being thought-provoking and providing 'a stark realisation'. Participants in Sinclair et al.'s (2012) discussion paper use the word 'insight' in their reflections, which is a consistent term used in all the papers discussed so far. From the reflective commentaries in Sinclair et al.'s paper (2012), it is not clear when they had been written. Perhaps it would have been beneficial to know if this was soon after the classroom experience or whether the participants had been back in practice. Although the project discussed by Sinclair et al. (2012) is not described as a research study, the discussion and reflections provide insight into the impact of involving service users in nurse education and, as such, are important in the development of the research strategy discussed in the next chapter.

Austin et al.'s (2013) findings predominantly focused on the skills that their participants obtained from the event rather than the involvement of children and young people. However, some students commented that the exercise provided them with a flavour of the chaos associated with a disaster and having to deal with mass casualties. Austin et al. (2013) highlight how service users can be included in nurse education, but the evaluation of their input was minimal. The authors recognise the

limitations inherent in their work and suggest that future research should address the effectiveness of paediatric simulation. This could be achieved by using a more robust approach to data collection and analysis. In order to improve the experiences for nursing students it is vital that evaluations are obtained, and, as demonstrated above, these are sometimes brief and, in some cases, inadequate.

Felton et al. (2013) conducted a pilot study to investigate a shared simulation learning experience for mental health and CYP nursing students. Service users, nurses (mental health and CYP), youth workers, a youth theatre group, lecturers and undergraduate nursing students attended a workshop to co-design a simulation scenario. The aim was to provide a shared learning experience for mental health and CYP nursing students. Felton et al. (2013) stated that the youth theatre workers played the role of a person who had self-harmed and the CYP and mental health nursing students were required to assess the person together. The students evaluated this as a positive learning experience; however, the authors do not report on any findings regarding the input of service users. The youth theatre workers were involved in the debriefing, and Felton et al. (2013) state that they were able to provide insight from the perspective of a young person and service user. However, the service users who participated in the workshop were not included in the debriefing, which may have provided a greater insight.

Barnley (2017) and Felton et al. (2018) both evaluated the impact of service user involvement on the learning of nursing students in the classroom. Barnley (2017) invited two young service users to share their patient journey with a small group CYP nursing students, whereas Felton et al. (2018) involved service users with a full cohort of CYP, mental health and adult nursing students (n=198). Whereas Barnley (2017) involved service users in the classroom to discuss their patient journey, Felton et al. (2018) reports that service users were involved in a wider range of activities. Alongside the lecturers, the service users co-developed learning outcomes, online activities, a classroom discussion and lectures. A one-day workshop was organised for the service users to prepare them for the sessions, which was followed up by smaller individual meetings of the group with the lecturers.

However, Barnley (2017) found that students valued the experience in terms of empathy, confidence and empowerment. Barnley states that the nursing students

had developed a greater insight into the thoughts and feelings of a service user. The findings are discussed briefly in Barnley's paper, whereas Fenton et al. (2018) provide more depth. The key findings were that nursing students found the sessions engaging, interesting and applicable to practice and helpful for developing their communication skills and recognising the significance of person-centred care. Felton et al. (2018) presented a written reflection from one of the service users, yet identified that evaluating the experience more formally through interviews would have provided a deeper insight. They also recognise that it would have been beneficial to have sought the views of the lecturers.

Carter and Brown (2014) held a panel symposium in which three parents (all of whom had a child with complex needs) were asked questions by the students. It is not stated how many students were involved in this experience, but it is assumed that they were undergraduate children's nursing students. However, the students were asked to evaluate the session and identified that this enabled them to become more knowledgeable about family requirements and reflect on their own practice. Although Carter and Brown (2014) present a mere snapshot of the students' views, it is comparable to the student evaluations and reflections discussed in previous papers (Fenton, 2014; Price, 2004; Rhodes, 2013; Sinclair et al., 2012).

To summarise, it seems that although the evidence base is sparse and what exists is weak and of poor quality, service user input into nurse education has a perceived positive effect on the teaching and learning of undergraduate students of children's nursing. However, this is not the only means by which children and young people can make a contribution to nurse education, and their involvement in curriculum development is explored in the next section.

2.6.2 Children's and young people's involvement in curriculum development and design

A consistent theme was identified from the review that related to the involvement of children and young people in curriculum development and design. Several of the papers included in the review focused on the benefits and process of involving service users and carers in curriculum and module development (Fallon et al., 2008; Fletcher et al., 2011; Griffiths et al., 2012; Randall et al., 2008; Randall & Hill, 2012; Summers, 2013).

Fletcher et al. (2011) and Randall et al. (2008) hoped that the views of children would help to inform a new degree programme that was being developed at the time. In Randall et al.'s (2008) study, the findings were analysed using a framework approach and it was reported that professional persona, attitude, personal qualities and cognitive, psychomotor and experiential learning were all important. The findings of this small-scale consultation are informative and certainly support engagement with children and their input into nurse education and curriculum planning. However, although they point out that the data provided "should" inform the curriculum, it is not stated how and when this will be achieved. Similarly, Fletcher et al. (2011) did not state how the findings would specifically inform the new curriculum, yet identified some fundamental skills that children and young people want a children's nurse to possess. These included being approachable, helpful, reassuring and supportive.

Randall and Hill (2012) discussed the involvement of children in developing the undergraduate curriculum. They criticised Randall, Hill and Stammers (2008) as being somewhat tokenistic in their approach to involvement and hence had learned from this and developed a more robust strategy. The aim of the project was to consult with children and young people on what makes a good nurse and for this to be more than a one-off consultation. Their intention was that the findings would be integrated into the undergraduate children's nursing curriculum.

Randall and Hill (2012) recognised that much of what the children and young people expressed is already embedded in the undergraduate children's nursing programme, and hence the value of this study is questionable. However, as in the case of Randall et al. (2008), it is important to recognise that engagement with children and young people can at least confirm that the curriculum does address the needs of service users. In turn, Randall and Hill (2012) were able to seek the views of children and young people who had a mental health problem, who are often excluded from research such as this.

Summers (2013) conducted a similar qualitative project that aimed to seek the views of children and young people to inform curriculum development. Summers found that communication, transitioning to adult services, accessing mainstream education and going clubbing were valued by children and young people. The results from this have been used to inform the content of some of the children's field of practice module in

the undergraduate nursing programme. In particular, certain narratives have been used in this module to enhance the students' understanding of holistic care. There is no discussion relating to student feedback regarding this, and it would be beneficial in the future to evaluate students' opinions about this aspect of the module.

The findings from Griffiths et al. (2012) were reported and discussed in depth. In brief, the results concluded that service users and carers valued 'caring' qualities the most. These included empathy, communication skills, non-judgemental patient-centred care and listening (Griffiths et al., 2012). The strategy for continued service user and carer input is described. There is, however, very little discussion that specifically focuses on how these findings will be integrated into the new nursing curriculum. More detailed discussion could have been provided on this such that the impact over time could be understood more clearly. What is noted is that the researchers report the findings from the parent groups, which suggests parents had a position at least equal to that of the children and young people who were also involved. This is a common theme with parents being used as the proxy voice or the most knowledgeable other. This is significant because it displaces children's and young people's views, opinions and insights from being the most important.

Whereas most of the works included in this review were concerned with undergraduate programmes, Fallon et al. (2008) carried out a project that aimed to gather teenagers' and young people's views to inform an 'adolescents with cancer' post-registration module. The results that were reported suggest that the most important quality was having a sense of humour, followed by having knowledge about cancer and its treatment and side effects and clinical skills. Most of the comments generated by the teenagers and young people were already built into the module. Fallon et al. (2007) state that the importance of having a sense of humour was overwhelming amongst the participants, and the module was adapted to include this. In a later paper Fallon and Smith (2007) discuss in more detail how the concept of a sense of humour was integrated into the module, and the students were asked to complete a questionnaire relating to the session. Fourteen students completed the questionnaire. There were only four questions in the questionnaire with Yes/No responses. Significantly, 11 students (85%) felt that the sense of humour session should continue to be included in the module. Those who did not feel it should be included expanded by saying that most people ought to have a sense of humour and

that it wasn't something that can be taught (Fallon & Smith, 2007). Perhaps if young people were included in this session and could explain to the student nurses why this is important, the students may feel differently about this.

It is worth noting here that few authors have reported on the value of involvement for the young people who engaged with the project. There seems to be a taken-for-granted attitude that individuals or small groups of young people can and do speak on behalf of others. It also seems to be too easy for researchers in this field to fall into tokenistic practice. The reasons for this are not clear but may be associated with maintaining long-term relationships with young people who have dynamic lives and changing priorities. It is also possible that is it simply easier to engage with students and parents rather than children and young people. It seems to me that non-tokenistic involvement would require being included not only in developing module and programme curricula and content but also in delivery and assessment of the impact of the content on students' learning and performance.

2.6.3 Service user involvement in the recruitment and selection of nursing students

Here, the involvement of service users in the recruitment and selection of nursing students is presented and the benefits of such initiatives are identified. Four of the papers that are reviewed involved consultations with children and young people that would assist with the recruitment of CYP nursing students (Carter & Brown, 2014; Rouse & Torney 2014; Stevens et al., 2017; Summers, 2013).

In Summers's (2013) study the young people suggested that good communication skills, caring and kindness were paramount. Applicants were asked to respond to this and were scored accordingly by the interviewer. Service user involvement in the recruitment and selection of student nurses is important. Summers (2013) describes a tokenistic method of achieving this, and there is some way to go before this can really be considered as service user involvement. In contrast, Rouse and Torney (2014) reported on their work with eight service users and carers who had been recruited to participate in the recruitment of student nurses during the group activity in the interview process. This included interviewing students for all fields of practice (adult, mental health and children's nursing). An online questionnaire was used to evaluate the process, and all those involved in the interview days were asked to

complete this (lecturers, practitioners, service users and applicants). Their results indicated that 88% of students, 92% of academics, all four service users and carers and all practitioners concurred that the involvement of service users and carers in the recruitment of students was beneficial and appropriate. All service users, carers and practitioners agreed that the selection process had been enhanced, with 85% of both applicants and lecturers agreeing.

The general consensus was that recruitment and selection was a collaborative effort, and one service user commented that their involvement was an "essential" element of the process. In research with a similar aim, Carter and Brown (2014) asked children and young people to compile some questions they would ask candidates at interview if they were on the panel. Four examples are provided, one being "Are you grumpy?" (Carter & Brown, 2014, p. 30). In turn, the information gathered from the children and young people was used to create literacy screening tests and to inform interview questions. This is not expanded upon, and therefore, although laudable, the children's and young people's contribution appears little more than tokenistic. On the other hand, Stevens et al. (2017) employed a phenomenological approach in seeking the views of service users and carers about their experiences of being involved in student nurse recruitment. The focus group interviews revealed that this was overall a positive experience for all those involved. However, the findings were not discussed specifically in relation to the different fields of practice, although the authors did comment that the young people appeared to display more energy, optimism and insight during their interviews (Stevens et al., 2017).

To summarise, it is evident that there are benefits to involving service users in the recruitment of nursing students. However, the papers discussed in this section focus on the views of those involved in the recruitment process, rather than those who were being recruited. Therefore, it is not known what impact this has on the experience of those being recruited, and in the future exploring this from multiple perspectives would be beneficial.

2.6.4 Impact of service user involvement on practice

The final theme that was identified relates to the impact of service user involvement on the practice of the nursing students. These findings were predominantly in relation to gaining further insight and developing their communication skills.

Several of the papers already referred to in this review included some discussion on how service user involvement does or could have an impact on practice (Price, 2004; Rhodes, 2013; Sinclair et al., 2012; Summers, 2013). Although this is not the central theme of the papers, it is evident that the impact on practice has been considered. Most notably in Price's (2004) study, 100% of the students (n=35) reported that the involvement of a parent in the classroom would certainly have an impact on their future practice as a children's nurse. Summers (2013) identified that it would be useful for students to receive feedback from service users and carers in practice. This project revealed the importance of listening to children and taking their feelings into account when delivering care. Thus, within the new programme at Canterbury Christ Church University children, young people and their families will be able to provide formative feedback to the students. This would be with support from the practice mentor and with the consent of the children, young people and their families. Issues that will be discussed with the service user will include the student's abilities to be professional and demonstrate good communication and interpersonal skills and the delivery of compassionate nursing care. The student will then be expected to reflect on this in discussion with their mentor and personal tutor. Summers (2013) recognises that this is a relatively new initiative. In the future it would be beneficial to evaluate the value of including this in the practice assessment process. This is something that has been included in the practice assessment documents at the University of Salford for over three years, but completion of this is not compulsory and it is rarely filled in. Perhaps this is something that mentors and students need more encouragement to complete.

In Sinclair et al.'s (2012) study, the two reflections from students included their perceptions that having a young 'looked-after' child speak to them in a classroom would have an impact on their practice. One student stated that listening to the young people emphasised the importance of having good communication and interpersonal skills in nursing practice. In contrast, another student felt that she would be able to deal with issues regarding consent and treatment and know better how to involve children, young people and parents more in decision-making (Sinclair et al., 2012). However, it would be interesting to ask the students to complete another reflection one year after the experience on whether they felt that it did have an impact on their practice and whether this changed how they interacted with young people and

delivered care, as was done by Rhodes (2013). That service user involvement helps students to communicate more effectively is reported by Price (2004), Rhodes (2013) and Sinclair et al. (2012). Moreover, there were some indications that parents wanted to be called by their name and not the commonly used 'mum' or 'dad'. The participant in Rhodes's (2013) study added that being on first-name terms helped develop relationships in practice.

Evidence from Rhodes's (2013) work also suggests that user involvement may have a lasting impact on future practice, as noted by her participant, who expressed that it gave her a great insight into the needs of children and families and helped deal with issues like conflict, for example.

An evaluative case study by Turnbull and Weeley (2013) reported their results in a single sentence, namely, that 278 out of 284 respondents had stated that the session with the service user had enhanced their understanding of the module. In particular, this was in regard to communication, multidisciplinary care and patient and personal insights. The evaluations focused on the types of pledges that had been made and were categorised according to the NMC (2007) essential skills clusters. This led to 15 children's nursing students completing pledges, of which seven were in the care and compassion category and six in the fluid and nutrition category. However, of the 15 only 10 were able to fulfil their pledges, with one of the reasons being a "lack of communication between shifts" (Turnbull & Weeley, 2013, p. 3). Of the 10 students who did fulfil their pledges, this had been influenced by service user involvement in their programme. As no details were provided as to who the service users and carers were, it could be debated that the pledges might have been different if children and young people had shared their experiences with the students. As Turnbull and Weeley (2013) point out, feedback was not received directly from the patients the students were caring for; rather, it was self-reported that the students had fulfilled their pledges. Certainly, this evaluative study confirms that service user involvement in nursing can enhance patient care. Perhaps, however, a future recommendation could be to include service user feedback in the practice assessment document, as advocated by Summers (2013).

To summarise, it is apparent that the nursing students in these studies had benefited from the involvement of service users in their programmes of study, specifically in

relation to how this would have an impact on their future practice. The nursing students identified that this was a positive experience and they would be able to apply this to their practice.

2.7   Discussion and synthesis of the findings

In this section, a critical discussion and synthesis of the findings is presented, which Whittemore and Knafl (2005) identify as the final stage of an integrative review.

2.7.1   Parents' versus children's voices

It is apparent from the review of evidence presented here that many of the studies used parents to represent service user involvement in the education of children's nurses, as opposed to the direct involvement of children and young people.

At times, when screening the titles and abstracts it was not clear whether children and young people had been involved. The title of Rhodes's (2013) paper is slightly misleading: 'Service user involvement in pre-registration children's nursing education' suggests, to me, that the 'service user' in the paper would be a child. However, it is not until the paper is read thoroughly that it emerges that this essential fact is not stated. The participant 'Anna' refers to 'parents' repeatedly in her interviews. Although it is not disputed that parents can provide a valuable learning experience for students of children's nursing, the voice of the child and insights of young people are missing, and this is an important omission.

Price (2004) confirms that there were several provisos that needed consideration if children and young people were to be included: that the child had to be well currently, a willing and informed parent would be involved, the parent had to feel confident in discussing personal issues in a group and a good relationship between the parent and lecturer was considered vital. Of course, such factors are important but tend to privilege adults rather than children and young people. This is not surprising given the prominence given to family- and parent-centred care in the UK. The only sentence that relates to the child is "explanations appropriate to his age and cognitive development have been given". In research and patient surveys parents have often provided the views of children. For instance, Griffiths et al. (2012) include just one teenager but six parents among 52 participants in their study of what qualities graduate nurses should possess. Livesley and Long (2013) state that parents are

used repeatedly as proxies for children and their views may not represent those of their children. Despite the increase in policy relating to listening to children's voices (Blades et al., 2013; DH, 2010, 2012), parents are still being employed as the proxy voices of their children.

2.7.2 Children and young people with cancer

In several of the studies reviewed the children, young people and parents who were consulted or involved in children's nursing education were being or had been treated for cancer (Barnley, 2017; Fallon et al., 2008 Fenton, 2014; Price, 2004; Rhodes, 2013; Summers, 2013). Although it is important to make determined efforts to include vulnerable children in all aspects of research, this means that the views of children with cancer are over-represented in this evidence base. Although important, their views and experiences may differ significantly from those of children with other healthcare problems and issues. Fenton (2014) explains that active engagement with children and young people with cancer is becoming increasingly more evident and suggests that this is due to a range of global childhood cancer organisations. However, this is not representative of the children and young people who are service users, as according to Cancer Research UK (2018) it is estimated that one child per 500 in Great Britain will be diagnosed with cancer by age 14. In some of the other studies vulnerable groups of children were consulted and involved in nurse education. Randall and Hill (2012) affirm that most of the participants were from a tertiary mental health unit. Sinclair et al. (2012) involved 'looked after children' in classroom sessions. As such, this represents some progress in ensuring that the voices of often marginalised, vulnerable groups of children are heard.

Interestingly, there are no studies or service evaluations that specifically state that they consulted or involved children with acute or short-term care needs. There is clearly a gap in the evidence base related to this group of children. Randall, Brook and Stammers (2008) state that they conducted their consultations with children on a 'children's ward'. Perhaps this was a general medical or surgical inpatient ward but, as it is not stated, this cannot be assumed. Such detail, however, is vital when it comes to analysing and critiquing the results. Children and young people with any healthcare needs should be involved in nurse education; that this is not so is evident from the literature presented here. However, these arguments are contrary to those

reported elsewhere. For instance, Smith (2007) has argued that the under-recruitment of marginalised and vulnerable groups has led to a lack of reliable and valid findings.

2.7.3 Consultations versus involvement

Here, the discussion focuses on the differences between consulting and involving children and young people in nurse education. Following the review, it emerged that several of the papers discussed how the researchers had consulted with children and young people rather than actively involving them.

Of the 19 papers included in this review, eight discussed the direct involvement of service users in student learning (Austin et al., 2013; Barnley, 2017; Felton et al., 2013, 2018; Fenton, 2014; Price, 2004; Rhodes, 2013; Sinclair et al., 2012). However, Price (2004) and Rhodes (2013) focused on parental views, and only six papers (Austin et al., 2013; Barnley, 2017; Felton et al., 2013, 2018; Fenton, 2014; Sinclair et al., 2012) discussed the direct involvement of children and young people with nursing students.

In mental health nursing, service user involvement in the classroom is reported on more extensively. Terry (2012) conducted a review of literature about service user involvement in the classroom in pre-registration mental health nursing and reported the findings from eight papers. Terry (2012) found that user involvement in the classroom can benefit student learning and a variety of teaching and learning strategies can be used to achieve this. However, in a later study Terry (2013) visited 15 UK universities to explore best practice in service user involvement in nurse education and concluded that service users and carers are underutilised in nursing programmes. In children's and young people's nursing this situation is exacerbated. Fenton (2014) asserts that engaging with patients' stories helps students have an improved understanding of a young person's journey in healthcare. In turn, Christiansen (2010) identifies that the delivery of compassionate, sensitive and individualised care can be enhanced through the powerful medium of listening to patients' stories.

'Involvement' is described as the process of children and young people being included in decision-making, whereas consultation encompasses seeking the views

of children and young people (Glasper, 2010). Arguably, in nurse education 'involvement' could include consultations with children to inform curriculum development. Service users can be involved in various ways from role-play and teaching to programme and module development. In essence, consultations are informative and useful in assisting with curriculum development, but they are not representative of active involvement; much of what is undertaken seems somewhat tokenistic. Within this review, only three studies 'involved' young people directly in teaching and learning (Austin et al., 2013; Fenton, 2014; Sinclair et al., 2012). However, seven studies 'consulted' with children and young people in order to inform curriculum development (Carter & Brown, 2014; Fallon et al., 2008; Fletcher et al., 2011; Griffiths et al., 2012; Randall et al., 2008; Randall & Hill, 2012; Summers, 2013).

Whereas it seems reasonable to agree that service user involvement enhances the student experience, the quality of the evidence reviewed here is poor and it is worthy of further research and exploration. More specifically, it is concluded that children's and young people's involvement in nurse education is sparse and requires further development.

2.7.4 Views of the service users and lecturers

Many of the papers specifically addressed the views and perspectives of students who had experienced service user involvement in their nursing programme, and in-depth student evaluations were sought (Austin et al., 2013; Barnley, 2017; Felton et al., 2018; Fenton, 2014; Price, 2004; Rhodes, 2013; Sinclair et al., 2012). However, little consideration was given to the perspectives of the lecturers and service users who had participated in the teaching session, with one paper specifically reporting this as a limitation (Felton et al., 2018). Price (2004) states initially that data collection would include "peer observation" and a "reflective journal". There is no discussion in addition to this, rendering the peer observation aspect of data collection insignificant.

Only one paper sought to explore the experiences of the service users in any depth, and this was in relation to the participation in student recruitment (Stevens et al., 2017). Thus, although Stevens et al.'s (2017) work offers insight into the benefits that service users can bring to the recruitment and selection process, no data were

collected from the interviewees about their experiences of being interviewed by a lay person.

Price (2004) briefly refers to how the parent felt after the session. The lecturer (Price) and parent shared a coffee and discussed the experience. The parent said she had felt "nervous" at the beginning and said it had been therapeutic as she could see how much progress the family had made. This was not considered part of the data collection, but the views of the parent could have been explored in more depth. Terry (2013) recognises that although the aim of service user involvement is to benefit student learning, users can also profit from the experience. This could be in relation to the kudos associated with engagement with an HEI and heightened confidence (Terry, 2013). This is evident in earlier studies in which service users describe involvement as a positive experience (Bennett & Baikie, 2003; McKeown et al., 2012; Rush & Barker, 2006). Rouse and Torney (2014) sought the views of service users who were involved in student recruitment. Only four service users completed the questionnaire, but they all agreed that they could enhance the student recruitment and selection process by being involved. Fenton (2014) briefly notes that Maya (the young person involved in the DLO) found the experience "enjoyable and cathartic" and displayed enthusiasm about her contribution. Sinclair et al. (2012) also state that the young people had enjoyed the way that the session had been run and were able to take some notes away to help their own development. Both Fenton (2014) and Sinclair et al. (2012) attempted to include the views of service users, but this was tokenistic and a more rigorous research approach is required.

Notably, Rouse and Torney (2014) evaluated the experiences of the lecturers, interviewees, practitioners and service users involved in student recruitment. This was the only study that included lecturers and service users in data collection. Four lecturers (38%) stated that having service users and carers involved in the group interview had made them feel apprehensive. Felton and Stickley (2004) reported that lecturers can perceive service user involvement in mental health nursing as a threat to their role and that they did not want service users to become the professionals. This aspect seems underexplored.

To summarise, it is evident that research has been undertaken that explored experiences of involving service users in the education of students of children's

nursing. However, views have been sought predominantly from the students and the perspectives of lecturers and service users seem to have received less attention and therefore require further investigation.

2.8   Summary from the literature review

The literature included in the review suggests that involving service users (whether they be children or their parents) has a positive impact on the learning of children's nursing students. However, what is not evident is the impact of this on the service users who are involved and the lecturers who usually facilitate the teaching sessions. Therefore, it is reasonable to suggest that this needs further exploration. It is important that outcomes are reviewed, as failing to explore the perspectives of all those involved is inadequate.

It is also apparent that children and young people are seldom involved in nurse education, and when they are their involvement is limited. Children are often consulted about issues relating to curriculum development; however, involvement requires more than this. Further strategies to involve children and young people in nurse education are paramount if participation is to be considered as a worthwhile intervention. They need to participate in the planning, delivery and evaluation processes of nurse education. In turn, simulation may provide an ideal opportunity for young people to become involved in the teaching and learning of children's nursing students. The outcomes and impacts from doing so for all participants warrant further investigation.

Children and young people with long-term health needs appear to be consulted more than children with acute care needs. This is contrary to what has been argued elsewhere. It is important that the views and perspectives of all children are considered, in particular, children who have little or no experience of healthcare. Therefore, it seems appropriate to investigate the views of those without long-term health needs. That said, there is clearly an urgent need to establish what benefits, if any, follow from the involvement of young people in simulation sessions with students of CYP nursing alongside an identification of what works for whom in what circumstances.

2.10   Positioning of children and young people in the literature

After undertaking the literature reviews and from a further understanding of the positioning of children and young people in society, I noticed that the studies in the review made little reference to the notion of agency. There were several papers that referred to the importance of listening to children's voices, but the underpinning theoretical concept of children's agency was not included. This adds further strength to my work, as what follows in this thesis concerns not only the importance of listening to children's voices but also children's ability to express agency, their social position and how adults can thwart their involvement.

Chapter 3

Research Design

3.1   Introduction

The findings reported in Chapter 2 point to the lack of good-quality research regarding young people's involvement in simulation. In this chapter, I build on the arguments previously presented to critically determine the aim, research question and objectives of this study. This is followed by reasoned arguments for the research approach that was adopted and the methods that were used. As noted in the previous chapter, the level and quality of evidence related to the involvement of young people in simulation sessions is sparse, and what exists often lacks rigour. This underpinned the need for further, robust research into the impact and outcomes of such work for those involved.

3.2   Philosophical framework

Mason (2018) proposes that social researchers should consider six questions (please see table 3.1) in order to understand exactly what the 'essence' of their enquiry is. Mason's assertions were useful in helping me to understand my ontological and epistemological standpoint and to ensure that the aim, research question and objectives of this research were interlinked so that I could complete a rigorous research study. In keeping with Mason (2018), the following section addresses how my ontological and epistemological standpoint influenced the research approach that I adopted for this study. First, it is important to establish what ontology and epistemology meant to me. For this, I found the definitions provided by Williams and May (1996) useful in helping me to understand my standpoint further[7].

Williams and May (1996) suggest that our moral and ontological thoughts about the social world will channel what we research, whereas the methodology selected will be influenced by our epistemological beliefs about the best way to answer the

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[7] Ontology is concerned with existence and the nature of those things that exist. Epistemology is concerned with how we know what we know and our justification for claims to knowledge (Williams & May, 1996).

research question and extract the knowledge needed to build the evidence base. As Mason (2018) notes, understanding the ontological perspectives involves identifying the nature of the phenomena that are to be studied.

Table 3.1:   Questions to understand the essence of enquiry (Mason, 2018, p. 4–17)

What the researcher needs to establish	What questions the researcher needs to ask	My answers
The social world: my ontological perspective	What is the nature of the phenomena, or entities, or social world that I wish to investigate?	The social world of young participants, people, student nurses, lecturers; high-fidelity simulation, nurse education, agency, involvement
Knowledge and evidence: your epistemological position	What might represent knowledge or evidence of the entities or social world that I wish to investigate? Am I being an epistemological thinker?	Experiences, perspectives of young people, student nurses and lecturers
Your broad research area	What topic or broad substantive area is the research concerned with? What is my research broadly about?	Voice/involvement of young people, simulation
Your intellectual puzzle	What is the intellectual puzzle? What's fascinating or intriguing? What do I wish to explore? What type or form of puzzle is it?	The involvement of young people in simulation Experiences, outcomes, impact of young people's involvement in simulation An experiential puzzle – the 'how'
Your research questions	What questions can I ask with my research, and how will they help me in addressing my intellectual puzzle?	How do young people, undergraduate students and lecturers interpret and make sense of the involvement of young participants in simulation sessions with undergraduate students of CYP nursing?
Your aims and purpose	What is the purpose of my research and what am I doing it for?	Refer to section 3.4

For me, an important intention of this work was to understand more about the involvement of young people in simulation. However, firstly and from the outset I realised that it would be impossible for me to deny my existing knowledge while recognising that this would bring a professional lens to the research. I was a researcher undertaking extensive research training by completing a PhD. However, I was also a registered CYP nurse and lecturer with responsibility for the education of undergraduate and postgraduate nurses across all fields. In addition, I had extensive expertise in the use of simulation in the education of undergraduate and postgraduate nurses. I was aware that I could not ignore the values that I embed in my work and these would have an impact on the research that I planned. For me, these values include being non-judgemental, providing support and empathy, acting with honesty and integrity and promoting hope and optimism. In my study, I would bring these values to the fore when working with the young participants.

With relation to my ontological position, I knew that these values would have an impact on the research that I would undertake and how they applied to my research would need to be considered. I was committed to 'user' involvement in nurse education and still believe this to be beneficial for young people and student nurses. I was strongly committed to ensuring that the young participants were involved in matters that have an impact on their lives and on the lives of others and those who are important to them. For the student nurses, I wanted to ensure that they had a positive learning experience following the involvement of the young participants in simulation. If the participants in the study felt strongly that the young people's involvement was an adverse experience, then my ontological standpoint would have been significantly challenged.

However, the impact and outcomes that follow the involvement of young people in simulation remained unknown. Therefore, having established my ontological position I had to give serious consideration to the epistemological stance for this work. In keeping with Mason (2018), I needed to establish what would constitute knowledge. Central to this was an understanding regarding who could be knowers about young people's involvement in simulation sessions. I take the position that knowledge regarding this would be best understood through the subjective insights of those who experienced and participated in the HFS sessions (young participants, student nurses and lecturers).

Having established my ontological and epistemological perspective, I sought a research paradigm that best encapsulated my values, what it was I wanted to research and whose knowledge was to be privileged, that is, the young people, student nurses and lecturers. Guba (1990, p. 17) describes a paradigm as "a basic set of beliefs that guides action". Several research paradigms are identified in the literature. The most widely discussed are positivism and post-positivism, interpretivism and constructivism, and critical theories – including feminism (Neuman, 2006; O'Leary, 2017). Post-positivism is most commonly associated with quantitative research and assumes that knowledge is best generated through the application of scientific methods such as experimental designs to test a hypothesis (O'Leary, 2017). As the evidence base is so weak and the theoretical and conceptual understanding of involvement underdeveloped, it seemed reasonable to reject the notion of measurement or experimental research. Rather, I determined that the subjective interpretations of those participating in the planned HFS sessions would be the best place to start this research investigation. This is in keeping with the arguments presented by the MRC (2008), and I contend that building knowledge in this way is important given the complexity of what is involved, the paucity of theoretical and conceptual understanding in this field and the lack of good-quality evidence.

According to Liamputtong (2013), the constructivist-interpretivist paradigm supports the notion that it is necessary to understand the human world of experience by relying on the participant's view of the phenomenon being researched. Blumer (1969) was one of the first proponents of constructivism and believed that the social world was constructed by the individual. Robson and McCartan (2016) explain that the interpretivist assumes the philosophical position that individual behaviour can be understood only in the context in which it occurs; it is the cognitive processes that arise from this that are studied. The aims and objectives of my study were to identify and explore the experiences and perceptions of the young participants, student nurses and lecturers; therefore, the constructivist-interpretivist paradigm was used to frame this research.

It is, however, worth noting that Williams (2000) suggests that the terms 'interpretivist' and 'qualitative research' are often used interchangeably in the literature. My understanding is that qualitative research is an umbrella term used to

describe a number of philosophical approaches from within the constructivist-interpretivist paradigm. All aim to enhance understanding of the human experience, perceptions, motivation, behaviour and intentions within social contexts (Fossey et al., 2002).

3.3   Broad research area and intellectual puzzle

Mason (2018) proposes that the broad research area tends to be what preoccupies the researcher most of the time in the early phase of their work. However, Mason asserts that this should follow on from establishing answers to the ontological and epistemological questions. Thus, for me, the broad research area concerned exploring the involvement of young people in simulation.

An intellectual puzzle involves the researcher being intrigued, fascinated and puzzled about what they are planning to research (Mason, 2018). I was intrigued to understand more about the involvement of young people in simulation. Moreover, I was excited to investigate whether those involved would benefit or not from this new initiative. In keeping with the constructivist-interpretivist approach, it was important that I sought this subjective information from those who experienced the phenomena. In keeping with Mason (2018), I recognised that this was an experiential puzzle, which focuses on the 'how' when formulating the research questions.

3.4   Research aim, question and objectives

The aim of this study, derived from what is already known (see Chapter 2), was:

To elicit, explore and discuss the outcome and impact of young people's involvement in simulation with undergraduate students of CYP nursing from the perspectives of the participants: young people, undergraduate student nurses and lecturers.

Research question

After I had established the broad area to be explored, the research question was devised to focus on the intellectual puzzle. This helped me to consider the central stakeholders in this study and was fundamental in helping me to adopt the most appropriate research approach. The research question was:

How do young people, undergraduate students and lecturers interpret and make sense of the involvement of young participants in simulation sessions with undergraduate students of CYP nursing?

As argued previously, the research question is important, as policy, practice and educational directives increasingly advocate for young people's involvement in all aspects of health and social care, including the education of nurses. However, there is little good-quality research evidence to support such involvement. It was anticipated that the findings reported from this study would advance the body of knowledge related to young people's involvement in nurse education by exploring the outcome and impact of such work. In addition, I wanted to ensure that I was sensitive to the lessons learned from the involvement of young people in order to make recommendations for others undertaking similar work in the future. Given this, and in keeping with Mason (2018), it was important to further develop the research question through a series of interrelated research objectives to ensure that I maximised the learning from the study. This was achieved through the development of the following five research objectives:

Research objectives

1. To identify and explore young people's accounts of their involvement in simulation sessions and any additional benefits identified by them from their engagement with a university.

2. To identify and explore lecturers' and CYP students' insights into the benefits or drawbacks of young people's involvement in simulation sessions with undergraduate students.

3. To establish the feasibility and usefulness of embedding young people's involvement in simulation with students of children's nursing.

4. To inform a School-wide (Health and Society) strategy regarding the involvement of children and young people in simulation.

5. To report and disseminate the lessons learned from working with young people in this context to add to the current body of knowledge related to young people's involvement in simulation.

Figure 3.1 provides a flow chart of the study protocol and the discussion which follows addresses the methods used to conduct the study.

Figure 3.1   Study flow diagram
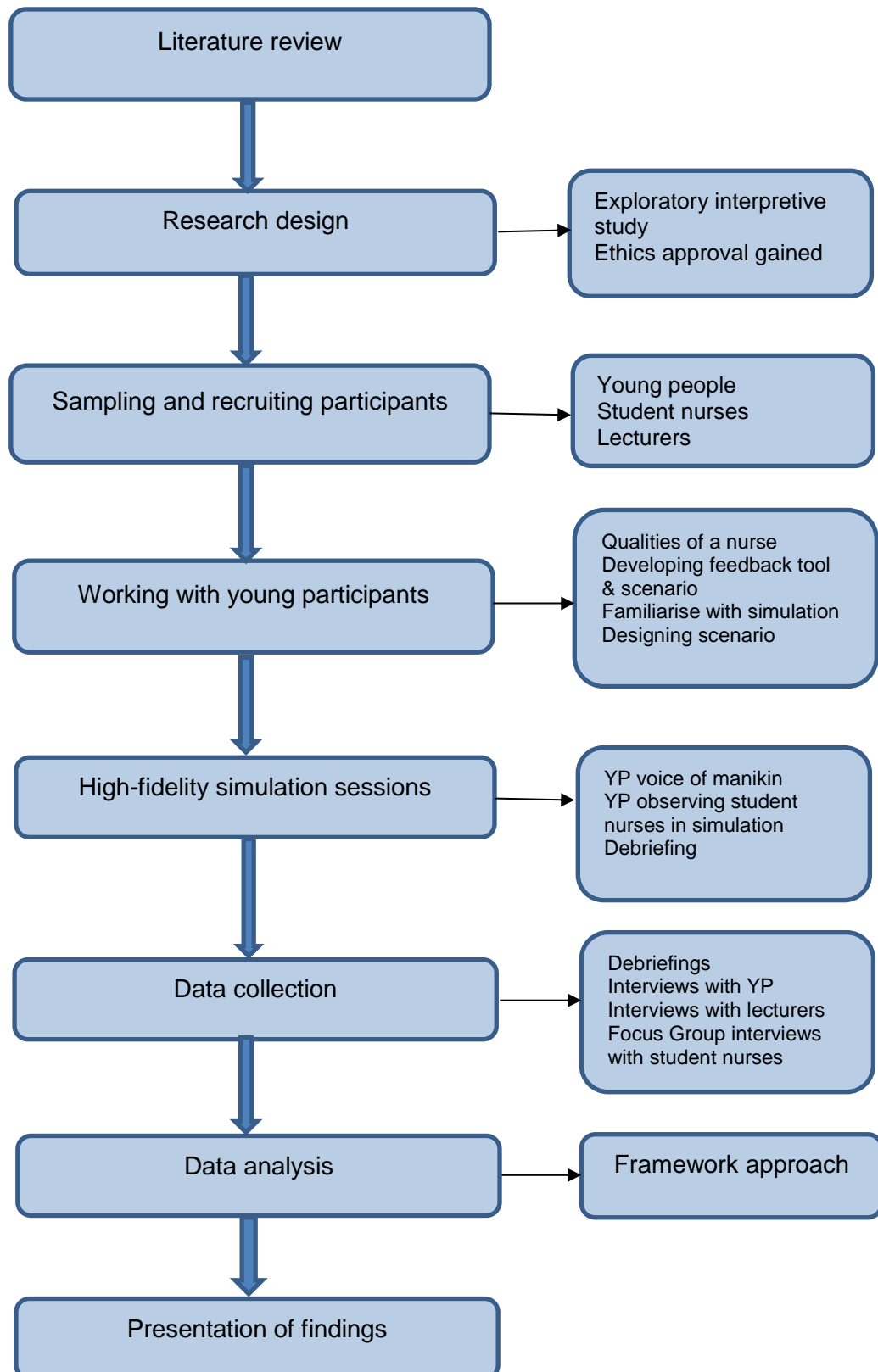
As the research question and objectives focused on the impact of involving young people in simulation. Key in this was the involvement of young people and it was important to design and deliver a training and development programme that would prepare the young participants to write the scenario and for them to be actively involved in the simulation sessions. This included the co-design of a simulation scenario and feedback tool, being a voice of a manikin and the provision of feedback to the student nurses in the debriefing. This programme occurred six months prior to the scheduled date of the simulation sessions and four full days were dedicated to the preparation programme. In keeping with the principles of Hart's ladder of participation (1992), the OCC Wheel of Participation (2012) and the theoretical framework, I felt it was essential that the young participants were involved in every stage of planning the simulation session and shared decision-making was important. Working with the young participants was about ensuring that they were involved in the co-production of the scenario case, the design of the feedback tool and that they understood what their role would be in the debriefings. As Aked and Stephens (2009) point out, it is essential that young people are viewed as assets in co-production and that there is a sense of shared responsibility for service delivery. As such, I felt strongly that I did not want to take control or finish any part of the design without input from the young participants.

However, the plans were flexible and adapted when required, considering the needs of the young participants. The main activities that were conducted during each of the training days are highlighted in Table 3.2. Due to the significance of the preparation programme in meeting the research objectives, chapter 4 is dedicated to providing a comprehensive discussion and critical insight regarding the training and development activities that were undertaken with the young participants. It also details the rationale for decisions made regarding the methods used in the preparation programme.

Table 3.2:   Outline of the preparation programme

DAY	MAIN ACTIVITIES OF EACH DAY
DAY 1	• Orientation to simulation ward for young people and meet the manikins • Meet student nurses

	• Identifying values of what makes a good nurse	
DAY 2	• Reviewing the values	
	• Formulation of a feedback tool based on 'qualities' using diamond ranking	
DAY 3	• Reviewing the nine qualities and grouping into three headings for feedback tool	
	• Writing the scenario	
DAY 4	• Finish writing the scenario	
	• Practice run-through of the HFS session with the manikin	
	• Discussion about provision of feedback	

3.5   Qualitative research approaches

Despite philosophical differences, there is a consensus that the aim of qualitative research is to understand and explore an issue from the subjective interpretation of another (Creswell, 2014; Gray, 2017; Robson & McCartan, 2016). Still, Creswell (2014) suggests that the qualitative researcher should choose from ethnographic, phenomenological, case study, grounded theory or narrative research approaches. All are fundamental approaches to qualitative research but are underpinned by different philosophical positions. Other methods include the historical method (Ingham-Broomfield, 2015) and action research (O'Leary, 2017). However, none of these approaches was found to be suitable with regard to the research aim of this study.

For instance, ethnography originates in anthropology and is primarily concerned with studying a culture or social group. Hammersley and Atkinson (2007) describe ethnography as a method by which the researcher positions him/herself in the day-to-day life of people for a period of time and observes, listens and asks questions in order to generate data that address the research question. However, as I was not adopting a cultural lens for this study, nor studying an existing cultural group in their day-to-day lives, ethnography would not have provided a suitable framework. Similarly, phenomenological research seeks to understand the 'lived' experience of individuals and explore what it is like for a person to experience a phenomenon (Seale, 2012). This approach aims to reveal the essence of everyday life

experiences and seeks to provide a deep insight into these experiences (Robson & McCartan, 2016). Given the aim of my research, this approach was also considered unsuitable. The grounded theory approach was also rejected, as it is an approach through which the researcher develops a general or abstract theory of an interaction, action or process grounded in the views of the participants (Creswell, 2009). I was not trying to generate a theory to define the phenomenon of young people's involvement in simulation, nor was I using an interactive and iterative approach to data collection and analysis (Glaser & Strauss, 1967).

Although at first worried that my research question, aims and objectives fell beyond the confines of such established and respected research approaches, I was reassured by Sandelowski's (2010) acknowledgement that researchers can be consumed by the concept of naming their approach, with the fear that without this the findings may lack credibility. However, as she points out, credible findings are derived from robust and rigorous research methods, rather than the naming of a particular approach. Mason (2018) agrees, asserting that not all research is suited to such specific philosophical frameworks. Mason (2018) continues by suggesting that the researcher should resist the temptation to choose an approach that is conventional or known within the researcher's field of practice. Moreover, arguing that qualitative research does not always have to encompass a specific framework or philosophy, she points out that it can fall within two or more philosophical approaches. Sandelowski (2000) agrees and adds that studies claiming to use, for example, ethnography or phenomenology are sometimes better depicted as using a qualitative, descriptive approach, as the researcher often places an 'interpretive spin' on the data.

As the overarching aim of this research study was to explore the participants' subjective accounts and meanings of young people's involvement in simulation, a qualitative interpretive approach was considered appropriate for shaping this research. Moreover, such an approach was consistent with my moral, ontological and epistemological positions and with the aim of the research. Krauss (2005) argues that ultimately it should be the aim of the study that guides the approach taken rather than the researcher's philosophical standpoint alone.

To further explain, qualitative research is exploratory, and Neuman (2006) and the MRC (2008) propose that exploratory research concerns the examination of a poorly understood phenomenon to develop initial ideas. In my study, such ideas related to the involvement of young people in simulation, which is currently underexplored. Descriptive research aims to describe what is in existence but may also establish new information or insights that were previously unknown (Offredy & Vickers, 2010). This was fitting for my research, as I hoped to generate new insights into the involvement of young people in simulation. As identified in Chapter 2, others who have conducted research with children and young people on their involvement in nurse education describe their philosophical approach to research as 'qualitative' (Griffiths et al., 2012; Summers, 2013). However, as acknowledged by Mason (2018) and Sandelowski (2000), some did not specify a specific approach at all (Randall & Hill, 2012). In agreement with Neuman (2006), my research focused on the aim of describing what may be going on whilst trying to establish new insights that were previously undiscovered. Following Sandelowski's (2000) lead, I decided that an exploratory interpretive approach would enable me to remain attuned to the data while acknowledging that I would bring an interpretivist spin to this work.

3.6 Ethics approval

Before any part of the study commenced, it was essential that ethics approval was sought and gained from the University ethics approval committee [application reference HSCR14/29] (please see Appendix 1). Rogers (2008) states that the role of the ethics committee is to protect the rights of research participants and provide assurance that the researcher is trustworthy and competent. In agreement with Gelling (2010), I found completion of the application forms arduous, although this was largely due to my unfamiliarity with the process. Ethics approval was granted after a request from the panel to make minor amendments to the original application. Most of the amendments concerned explaining information more clearly on the participant information sheets so that it was less technical, and the young people would be able to understand it. This was satisfying and as a result permitted me to gain access and entry to the students at a local college. A current enhanced Disclosure and Barring Service certificate was also obtained; this was a requirement of the ethics application, as I was working with young people. The recruitment

process of the young people started first, as I had planned to work with them several months before the simulation sessions took place.

3.6.1 Participant information sheets

All the materials that were used to recruit the participants and to gain informed consent were designed in keeping with the guidance and format provided by the University's research ethics committee.

These sheets provided the participants with information about the study itself, the role of the participant, potential risks and benefits, confidentiality and anonymity and provided a guarantee that they had the freedom to withdraw from the study at any time. This detailed information must be provided in order that the young participants were able to make an informed decision to consent to study (France, 2004).The information sheets for the different groups of participants varied slightly, especially in relation to the amount of technical language that was used (Appendices 2, 3 and 4). Participant information sheets should outline the research study in language that is accessible to the reader and aimed at an individual who has no expertise in the subject being studied (Health Research Authority [HRA], 2014). The initial feedback from the ethics committee suggested that the title of the study on the young participants' information sheet should be less technical and not include 'high fidelity simulation'. Therefore, it was amended to reflect the comments by the panel. My contact details were also provided, along with who to contact should the participant wish to make a complaint.

3.6.2 Written consent forms

Written consent forms were provided for all the participants and were designed according to the standard template provided by the University. There was no difference between the forms for the different groups of participants (excluding the header), and all signed forms were stored in a locked cupboard in the University and kept separate from any, in accordance with the General Data Protection Regulation (GDPR) (2018).

According to the HRA (2014), consent does not always have to be gained in writing and can be obtained orally. However, the local University research ethics committee suggest that the researcher submits a written consent form as part of the ethics

approval process. Consent is considered to be an iterative and ongoing process (HRA, 2014), and this was evident throughout all the stages of the research study. With regard to the young participants, it was emphasised on each subsequent day when I met with them that their participation was voluntary and they had the right to withdraw from the study at any time. In agreement with Alderson (2004), it was important that I remained vigilant for any signs that a young participant might want to withdraw, as this might not always be expressed verbally. This was particularly important after they had been orientated to the simulation room and seen the manikins, as they could have been frightened or intimidated.

3.7   Ethical considerations

In terms of ethical considerations and in keeping with Long (2007), a risk analysis approach was adopted. Issues associated with benefits and harm, anonymity and confidentiality, and autonomy were considered.

3.7.1 Autonomy

Gillon (1994) suggests that having autonomy means being able to make decisions independently. Further, McLaughlin (2015) proposes that respecting autonomy means to treat people as ends in themselves and not just as means. However, Schafer and Yarwood (2008) state that the way in which adults construct and understand childhood can have significant implications for how a researcher understands the concept of research and participation and how children and young people are engaged in research and decision-making. As Mayall (2013) suggests, a key component of research with children and young people concerns the undoubted power imbalance, and an intrinsic ethical consideration is ensuring that there is no coercion in terms of choosing to participate. In relation to children's agency when participants are recruited from schools, Heath et al. (2004) state that children may seem to be given a choice to participate but that it can be courageous to refuse and there can be an element of wanting to please or perhaps a fear that there may be consequences should they not participate. When I first met with the young participants I talked through my study with them and invited them to ask questions. The decision to participate was theirs, and there was no obligation to take part. I hoped that my explanations (verbal and written) of the study were comprehensive enough that they felt able to exercise their autonomy. However, it was not until I was

some way through the study that, for some, their autonomy had been impaired by the curriculum leader.

Although Creswell (2009) recognises that the researcher and participant should both benefit from a project, the issue of perceived coercion and power has to be considered as it can easily be abused (Neuman, 2006). As I was a member of the module that the student nurses were undertaking (and thus involved in marking assessments), the student nurses were recruited by the programme leader by placing a notice on their virtual learning environment platform. It was important that the student nurses were reassured that participating in the research study would not affect their progression on the programme. In turn, it was imperative that the student nurses understood that they would still be able to participate in the simulation session without having to participate in the research study. This ensured that no student nurse would be disadvantaged and reinforced the ethical principle of justice, namely, that participants were included and excluded on the basis of a fair and equitable selection process. Eleven students did not want to be involved in the research; however, only one of these students participated in the simulation without the young participants. They were either absent or sick, and I considered that their reasons to opt out of the research might have been associated with the anxiety of simulation rather than the input of the young people. Although this was not stated by the student nurses, I have many years of experience of facilitating simulation and there are usually several students who do not participate despite their attendance in theoretical sessions being high.

3.7.2 Anonymity and confidentiality

Anonymity and confidentiality were of relevance to all the research participants. Johnson and Long (2010) state that confidentiality is assured by anonymising the participants and organisations. However, despite the necessity of anonymity, Braun and Clarke (2013) recognise that participants may feel that their individual voices are being removed, which in essence opposes the theoretical framework underpinning this research. Therefore, it was important to emphasise to the young participants that anonymity concerned protecting their identity and that their individual and collective voices would still be represented and equally significant. Creswell (2009) proposes that some participants may insist that their identity does

not remain confidential; however, if this is the case, they must be cognisant of its potential implications. In particular, when direct quotes are cited data may be included that the participant may not have anticipated would be disclosed (Creswell, 2009), which in turn could have detrimental consequences. There could also be disagreements between participants if they did not all wish to have their identity known. Seale (2012) suggests that some participants may feel proud that their perspectives will become known to the public, whereas others may feel the opposite. There could be future consequences resulting from the research, but these cannot be predicted and are unknown. When I discussed this with the young participants, they all expressed that they felt comfortable with the findings being published and disseminated, and there has, to date, been no further communication from the young participants about this.

The participant information sheets and consent forms confirmed to the participants that anonymity and confidentiality would be maintained throughout the study. Furthermore, ongoing verbal reassurance regarding this was also provided throughout the duration of the study. The confidentiality and anonymity of data generated were assured in accordance with the Data Protection Act (1998) and General Data Protection Regulation (2018). All digitally recorded interviews were transferred to, and stored on, a password-protected computer on the day when they were generated, with the researcher having sole access to this. All the digitally recorded data (including the debriefings) were transcribed by professional transcription services who work to a strict code of ethics. All participants remained anonymous, and unique codes were used to identify each individual in the transcripts. Pseudonyms were assigned to all the participants (please see table 3.3). Student nurses marked with * participated only in the debriefings but did not participate in the interviews, which is discussed in a later section. All except one participant in the lecturer data set were female. Therefore, non-gender-specific names were given to this group of participants to protect the identity of the male participant. The data will be stored securely for ten years, after which all electronic and paper data will be destroyed or shredded.

Table 3.3:   Pseudonyms for participants

Lecturers	Young Participants	Student Nurses
L1 = Sam	YP1 = Sarah	StN1 = Julie
L2 = Danny	YP2 = Louise	StN2 = Claire
L3 = Pat	YP3 = Jenny	StN3 = Sandra
L4 = Chris	YP4 = Chelsea	StN4 = Mandy
L5 = Tony	YP5 = Amelia	StN5 = Leona
	YP6 = Gina	StN6 = Bridgit
	YP7 = Melissa	StN7 = Florence
	YP8 = Tara (no interview)	StN8 = Jackie
	YP9 = Heather	StN9 = Nicola
	YP10 = Holly	StN10 = Ameera
	YP11 = Lexy	StN11 = Andrea
		StN12 = Heidi
		StN13 = Belinda
		StN14 = Sajeeda
		StN15 = Paula
		StN16 = Melinda*
		StN17 = Catherine*
		StN18 = Talia*
		StN19 = Poppy*
		StN20 = Maya*
		StN21 = Karina*
TOTAL = 5	**TOTAL = 11**	**TOTAL = 21**

3.7.3 Risks and benefits for the young participants

Jones (2004) identifies that involving young people in research provides benefits such as developing research skills, certification, monetary reward and increased confidence. However, Richards and Schwartz (2002) identify that there are four possible risks to those participating in qualitative research: anxiety, distress,

misrepresentation in the findings and exploitation. Although there were no immediate risks to the young participants, I was aware that they could become distressed or nervous and/or feel intimidated during any stage of the study. Moreover, as I was using manikins, I was aware that the young participants could be frightened by them. Therefore, after I had recruited the young participants a follow-up visit was arranged to meet with them to tell them more about the research, answer any questions that they had and let them see one of the manikins. I decided to bring the child human patient simulator (SimJunior®) with me to this meeting so that they could visualise exactly what I meant by a manikin. From my extensive experience of facilitating simulation sessions using manikins, some individuals may react negatively to them. Initially, some of the young participants appeared curious and a little fearful of the manikins, but once they had been given the opportunity to touch them and see them up close they appeared to be less anxious. This was beneficial for limiting attrition, as I knew that after this first day they felt comfortable with this aspect of the study.

It was envisaged that the young participants could benefit directly from engaging with an HEI. In keeping with McLaughlin (2006), involving young participants in research is beneficial to them when it concerns issues that affect their own lives, and as a result they are no longer passive subjects of social structures and processes (James & Prout, 1997). More specifically, it could assist with their decisions to apply for a nursing programme, and, as anticipated, this was reflected in the data collected from the interviews. The young participants all identified that they had enjoyed the experience of being involved with the University and would discuss this on their future UCAS applications. They also stated that it had given them an insight into what student nurses do whilst they are in University. In turn, in accordance with McLaughlin (2006), the young participants would gain recognition for their contribution, receive remuneration and assist in the improvement of services that they may use.

3.7.4 Risks and benefits for the student nurses

There were also risks and benefits that required consideration for the student nurses. First, it was hoped that the benefit for them would be that they would gain a wider understanding of the importance of service user involvement in healthcare and use the feedback to improve their practice. In my experience, student nurses can

experience increased levels of anxiety when participating in simulation scenarios, especially when they are aware that their peers are observing them. Nielsen and Harder (2013) conducted a review of the literature in relation to the reasons for student anxiety during simulation and identified that one of the most pervasive themes was being observed or recorded. Similarly, Garrow (2014) found that student nurses felt uncomfortable when being observed by their peers and for some this provoked a sense of dread. Therefore, I was aware that such anxiety might be exacerbated, as the student nurses were being observed by young participants who were largely unknown to them. Ganley and Linnard-Palmer (2012) recommend that helping student nurses feel safe during a simulation could be enhanced by factoring in some time-out before the simulation for the student nurses to collect their thoughts, and staff members could provide any support that is required during this time. In keeping with Ganley and Linnard-Palmer (2012), in order to alleviate some of the anticipated fears I arranged for the student nurses to be met by one of the lecturers prior to entering the simulation room. The lecturer was asked to brief the students on the simulation and provide reassurance, and the students had the opportunity to ask questions prior to starting the simulated scenario. In this I ensured that the students felt as comfortable as possible with the simulation and that they had the choice to withdraw from the study at this point. It was important that they did not feel coerced or under pressure to participate even though they had turned up on the day. I ensured that additional academic staff were present and available to assist with emotional support if required. Although this was not expected, I asked two of my colleagues to be on 'stand by' for the days and be available to come and talk to the student nurses if they became distressed or upset at any point. As Johnson and Long (2010) point out, in certain cases there may be times when the researcher needs to intervene in order to reduce harm or, as in the case of this study, to alleviate anxiety or distress. During the interviews the participants were also reassured that they did not have to discuss anything that they felt uncomfortable with. However, if they felt they needed to discuss any issues outside the debriefings or interviews an opportunity to do so would be arranged.

3.7.5 Risks and benefits for the lecturers

There were no obvious risks and benefits identified for the lecturers participating in the HFS sessions as this was a component of their everyday practice. However, the

opportunity to participate in the interviews would enable the lecturers to contribute to future practice and understand more about the involvement of young participants in simulation.

3.8   Sampling

There are two main methods of sampling, namely, probability and non-probability. Bryman (2008) identifies that probability sampling involves the random selection of a population, whereas non-probability sampling does not use a random selection method and is widely used in qualitative research. Non-probability sampling has a number of approaches: convenience, purposive, snowball and theoretical. Purposive sampling is adopted when the researcher needs to recruit participants who have particular knowledge about the research being conducted and can provide the necessary data to answer the research question (Creswell, 2014). In keeping with Silverman (2000), the sampling approach used for the three different groups of participants was purposive, as he suggests that purposive sampling enables the researcher to select participants who possess a feature or process that meets the needs of the research.

The inclusion and exclusion criteria were identified for each group of participants and are summarised in Table 3.3. It is important to note that if any of the participants demonstrated a fear of manikins (pediophobia) then they would be excluded due to ethical issues and my intention to minimise harm.

Table 3.4:   Inclusion and exclusion criteria for study participants

PARTICIPANT	INCLUSION	EXCLUSION
YOUNG PERSON	16–19 years old Studying a programme relating to health and social care Currently enrolled on a programme that would span one year	Disclosure of a phobia of dolls (pediophobia)
STUDENT NURSE	CYP student nurses, Year 2, Semester 3	Disclosure of a phobia of dolls (pediophobia)

| LECTURER | Lecturers at the University who are registered children's nurses | Solely registered as adult, mental health or learning disability nurses |
| | Have some experience of facilitating simulation with manikins | |

3.8.1 Access to the young participants

Gaining access to research participants often requires a formal agreement from a person who has permission to grant access (Robson & McCartan, 2016). In turn, when undertaking research with children and young people, access can be challenging owing to the role of gatekeepers (further discussion on this is provided under the next heading).

Researchers working in the CYP nursing group (CYP@Salford) at the University of Salford have established good working relationships with local schools and colleges. An initial email outlining the proposed research was sent to the educational visits advisor for the local council's children's services department. This email included a copy of the participant information sheet and asked for support in recruiting young people from local schools/colleges. A positive response was received and, although the educational visits advisor stated that he could not assist directly, he was able to provide me with contact details of those who were in a better position to help. Once this response had been received, I decided that I would investigate (in more depth) the schools and colleges that had courses specifically relating to health and social care. I considered that those who were studying health and social care programmes had chosen this further study and would have an interest in the subject area. In turn, I hoped that they would be intrigued by my research, as it would also provide them with an insight into aspects of a CYP nursing degree programme. One local college was of interest to me, as it provided a nursing cadets' course and diploma and A Level courses in health and social care. Such courses are often attended by those considering a career in nursing. The lead transition mentor from the local sixth form college was approached. The initial response was positive, with the lead transition officer stating that the research sounded appealing for their young people and letting me know that they had forwarded my details to the head of department and

curriculum leader. I started to consider at this point that the curriculum leader would be the gatekeeper for the study, and I asked if I could attend the college to meet her at a time that was convenient for her.

3.8.2 Gatekeepers

It was fundamental that I was able to develop a good relationship with the curriculum leader Diane (pseudonym), as I perceived her as the main adult gatekeeper for the study. As Corsaro and Molinari (2000) explain, gatekeepers are those who have various degrees of control over access to, and the activities of, those involved in the research. As Coyne (2009) identifies, recruiting children into research can be challenging, and the role of the gatekeeper is to ensure that the child or young person is protected and free from exploitation. Diane was in a senior position at the college and was also responsible for maintaining the professional image and reputation of the college.

Diane was keen to assist with my access to young people to be participants in the research study and suggested that her health and social care diploma students would benefit from this. We arranged a mutually convenient date and time to meet. The aim of the preliminary meeting with Diane was to introduce myself and talk through my research. It was important that I was able to explain the predicted benefits that this would have for the college students, especially as it could potentially have a negative impact on their studies, as time away from college would be required. I reinforced that some of the benefits would be to increase their understanding and education about being a student nurse and could lead to positive outcomes in the care that is delivered to children and young people, such concepts being supported by Participation Works (2009).

The meeting between Diane and myself appeared to be successful, and she thought participation in the research would be an excellent opportunity for her learners (this was the word she used for the young people). It was at this point that I realised the importance of this first meeting. Had I not obtained the cooperation and support from Diane, access to the young people could have been problematic. In addition, she stated that the noticeable enthusiasm I had for the study had grasped her attention and that she was excited by the prospect of being involved. Diane explained that she felt privileged that I had approached the college and informed me that opportunities

like this do not often present themselves. At this point I had not understood that limited extracurricular opportunities were available to the college students, but I became aware of this later during a conversation that I had with Diane.

I was informed by Diane that over 20 young people had expressed an interest in being involved. This information emerged retrospectively in a conversation that I had with Diane after the simulation day; she informed me that she had asked all the young people to submit a written piece of work (of about 500 words) explaining their reasons for wanting to participate. From the submissions, Diane selected those people she thought had produced a good piece of work and also those she felt would be committed to the study. On reflection, I could have potentially recruited more young people to my study, but it was important that Diane supported each of the young people's involvement, thus epitomising the role of the gatekeeper in this study and my relationship with Diane. Perhaps I could have engaged more regularly with Diane; as Balen et al. (2006) suggest, regularly involving gatekeepers avoids the risk of the gatekeeper undermining the decisions of children and young people. As a consequence, having realised that Diane had introduced this stage into the sampling process made me question how inclusive the study was. In turn, she had not informed me, and, although I thought that this was unintentional, it seemed that Diane had exerted her power or position to select those she believed would be 'good' students to participate. As McLaughlin (2015) highlights, gatekeepers may think they are being helpful by identifying or selecting those who they think are confident or will impress the most. Denying entry to a study to a potential participant who has been deemed unsuitable by the gatekeeper can prejudice the data. Diane perhaps unwittingly exercised her power owing to the position that she held at the college, ensuring that only particular young people were given the option to participate. While I acknowledge that not all young people would want to engage in such a project, I had determined that all should be given the opportunity. This brings to the fore the role of gatekeepers and the impact they may have on young people's inclusion and involvement. As noted by James and James (2004), children remain subordinate to adults, and, as such, adults 'regulate' children. Some adults enforce their own ideologies of childhood, namely, through suppression or denial of the agency of children and ignoring importance of their ideas and, what is most concerning, their essential dependence on adults (James & James, 2004). Thus, in this study it

seemed that the young participants were dependent on Diane as gatekeeper in that she decided whether or not they could participate.

The first indication of a wish to be involved came from the submission of the written work. Diane had been surprised to receive this from two young people in particular. Her concern rested on fears that they would not have taken the study seriously. She was concerned that they might have acted in an unprofessional manner or 'messed about'. However, to her surprise, they remained committed throughout the study. Still, it should be acknowledged that those who did not complete the written piece of work were denied this opportunity and that I had no influence over this.

3.8.3 Access to the student nurses

The module leader was approached and asked if they would agree to the study being carried out in their module; they agreed without any concerns expressed. Student nurses were invited to participate in the study by the programme leader, who placed an announcement detailing the study on the relevant Blackboard® site along with the participant information sheet. It was important that the programme and module leaders supported this study and were considered additional gatekeepers of the study.

3.8.4 Access to the lecturers

As a lecturer working closely with the staff I was recruiting, I was aware of a possible risk of unintended coercion with those who were approached. The coercion of participants in research is unacceptable. To respect autonomy the decisions of properly informed, uncoerced and competent participants are to be privileged Beauchamp and Childress (2013). This was addressed by asking the Professor of Child Health Nursing to send an email invitation with the relevant participant information sheet to those with appropriate expertise in simulation work and children's nursing. Those interested in taking part were asked to email the researcher directly indicating their willingness to participate or to ask questions before deciding to do so. In keeping with the research ethics committee requirements, they were given 48 hours to decide.

3.8.5 Recruiting the young participants

As the essence of my research was to establish young people's perceptions about their involvement in nurse education, purposive sampling was used to recruit 11 young participants.

Table 3.5:   Demographic data (young participants)

AGE	ETHNICITY	SEX	COURSE STUDIED
17 years = 7 participants 18 years = 4 participants	9 = White/British 1 = Irish 1 = African	11 = female	8 = Level 3 health and social care 3 = Level 3 health and social care (NHS Cadets)

Initially, the number of young people who agreed to participate in the study was 15, although by the end of the study there were 11 participants (please see figure 3.2). Demographic data for the 11 young participants is provided in Table 3.5. It was envisaged that this number would provide a diversity of views and perspectives whilst ensuring that there was sufficient peer support for the young participants when working in small groups. Within the literature there is no real consensus on the sample size required for a qualitative research study. However, Braun and Clarke (2013) suggest that between 15 and 30 individual interviews tends to be commonplace when the aim is to analyse patterns across the data. On the other hand, Mason (2018) and May (2011) suggest that the key question is whether the sample provides access to enough applicable data in order to address the research question.

3.8.6 Recruiting the student nurses

A notice was placed on the students' virtual learning environment by the programme leader with details about the study. Students were invited to contact the researcher directly with any questions before deciding whether to take part. 48 hours after this notice had been placed, I took the opportunity to go and talk to the students to ascertain who would like to participate and to answer any questions that they had.

The whole cohort of CYP student nurses (which equated to a total of 32 participants) were invited to participate; however, to gain diverse perspectives a minimum of 10 participants were required. If any students did not choose to participate in the study,

Figure 3.2:   Flow chart illustrating young participant involvement

```
┌─────────────────────────┐          ┌─────────────────────────┐
│ Young people invited to │          │ Young people who expressed│
│       participate       │─────────▶│ initial interest to participate│
│         N = 27          │          │         N = 25          │
└─────────────────────────┘          └─────────────────────────┘
             │
             ▼
┌─────────────────────────┐          ┌─────────────────────────┐
│  Young people who signed │          │  Young people withdrawn by│
│   consent to participate │─────────▶│        gatekeeper        │
│         N = 15          │          │         N = 4           │
└─────────────────────────┘          └─────────────────────────┘
             │
             ▼
┌─────────────────────────┐          ┌─────────────────────────┐
│ Young people who participated│       │  Young people who did not │
│    in the HFS sessions   │─────────▶│ participate in interviews│
│         N = 11          │          │         N = 1           │
└─────────────────────────┘          └─────────────────────────┘
             │
             ▼
┌─────────────────────────┐
│ Young people who participated│
│      in interviews:      │
│       **N = 10**         │
└─────────────────────────┘
```
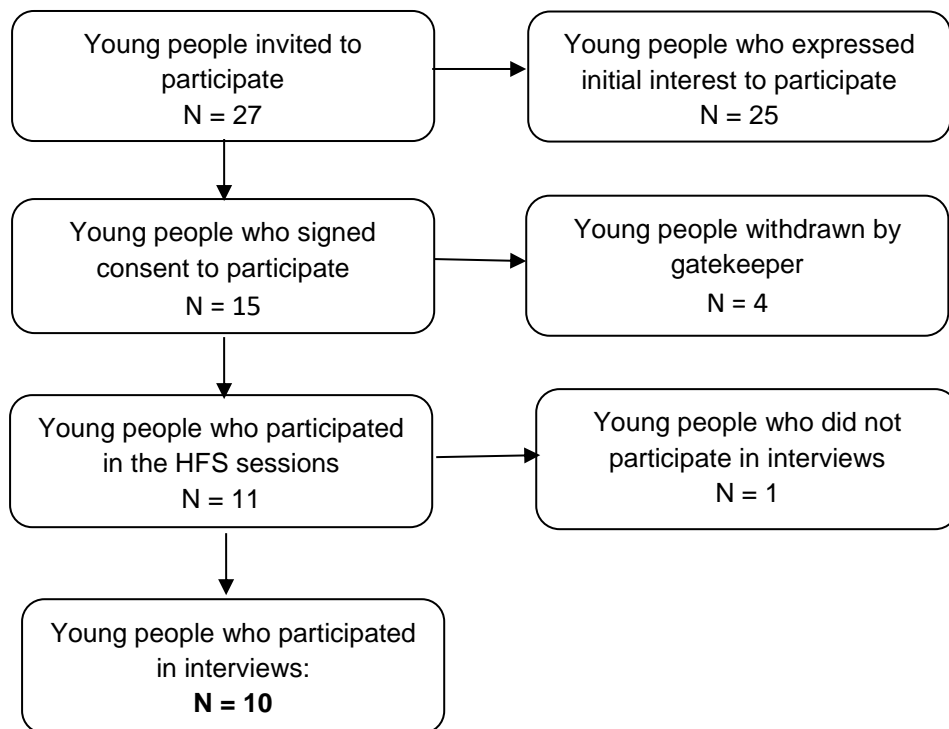
they were still offered the opportunity to undertake the simulation session (without
the intervention of the young participant), as it was an integral component of the
module. Initially, 25 student nurses agreed to participate in the study; however, four
were absent on the day of the HFS sessions, leaving 21 participants (please see
figure 3.3).

3.8.7   Recruiting the lecturers

Five members of academic staff working in the field of CYP nursing and experienced
in the use of simulation were invited to participate in the study. For the purpose of
this thesis the term 'lecturer' will be used to describe all grades of academic staff.
The lecturers would be the facilitators of the simulation, and therefore the terms
'lecturer' and 'facilitator' may be used interchangeably. Please see figure 3.4 for
lecturer numbers recruited for the HFS session and interviews.

The sample size was small in comparison with the number of young participants and
student nurses recruited. However, this was unavoidable owing to the specific nature
of the research study and the lecturer participants required.

Figure 3.3: Flow chart illustrating student nurse participation in the simulation session and interviews
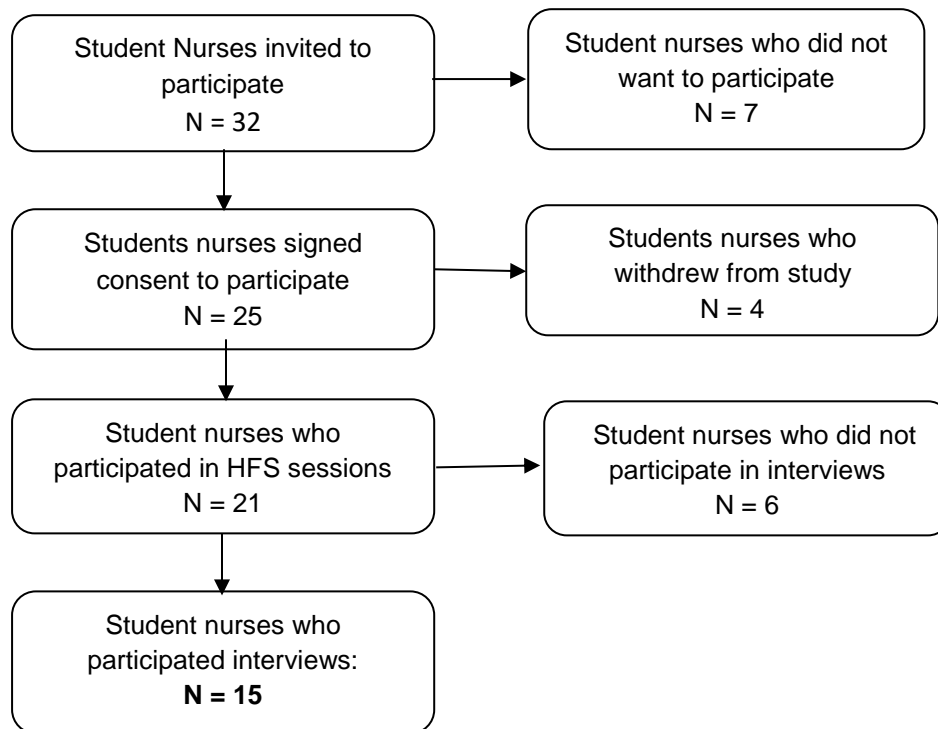
I was aware that with such a small sample diversity of perspectives may be limited and the data may not be as 'rich' as initially intended. Mason (2018) emphasises the importance of recognising whether the sample provides enough data and focus to answer the research question. Following data analysis, I had the necessary data to answer the research question.

3.8.8 Approach to the young participants

Initially, I felt that the young participants were wondering what the purpose of my visit was and that I needed to explain exactly why I was visiting their college. However, after I had spoken to them Diane explained that she had only told them that I was an external speaker from the University of Salford and she had not disclosed the context of my visit. Although she had not lied to them, she had withheld information. Diane is an experienced college tutor and was aware that college students are usually more engaged if they know that an external speaker is facilitating a session.

Figure 3.4: Flow chart illustrating lecturer participation in the simulation session and interviews

```
┌─────────────────────────────┐
│   Lecturers invited to      │
│   participate               │
│          N = 5              │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐
│   Lecturers signed consent  │
│   to participate            │
│          N = 5              │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐
│   Lecturers who             │
│   participated in HFS       │
│   sessions                  │
│          N = 5              │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐
│   Lecturers who             │
│   participated interviews:  │
│          N = 5              │
└─────────────────────────────┘
```
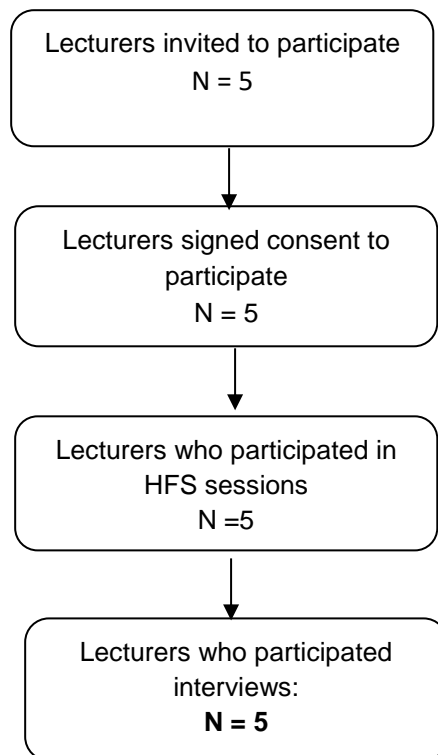
I had brought the manikin with me so that I could provide a practical and hands-on demonstration following the discussion about the study. Coad (2012) recognises that successful involvement and meaningful contributions from young people are reliant upon the strategies used to engage with them. In turn, I hoped that addressing the college students with a relaxed, friendly and enthusiastic approach would assist with their engagement and willingness to participate.

I was mindful that I needed to start to build a trusting relationship with them from the outset and wanted them to perceive me as approachable, yet professional. Braun and Clarke (2013) discuss that in order to be a good qualitative researcher one must display sound interactional actions and be able to reassure participants with a warm and friendly demeanour. In keeping with Shaw, Brady and Davey (2011), I chose to dress informally so that I did not exude an authoritarian stance and avoided the use of academic, technical or research-type language. It was imperative that I was able to demystify research terms and concepts, as advocated by Participation Works (2009). Certain terms were simplified: 'sampling' was explained as 'asking for volunteers', data collection was described as gathering lots of information, and so

forth. In keeping with guidance from the OCC (2012), I considered the appropriateness of the language that I used, explained the research process unpretentiously and avoided using sarcasm and demeaning comments. In accordance with the theoretical framework, by adopting this approach I was aiming to minimise the power relationships that could be perceived by the young people. There were arguably two types of potential power relationships in my study: the relationship between a researcher and a participant and the relationship between a young person and an adult. Mandell (1991) debated that the researcher could adopt a 'least adult role' whereby he or she attempts to be accepted as part of the child's daily life and activities, and this is perhaps what I was attempting to do in the way that I dressed and conducted my behaviour, which the OCC (2012) recommend require careful consideration. However, as Mayall (1994) proposes critically, children and young people are unlikely to be duped by 'least adult' behaviours in their pursuit to mitigate or defuse the adult powers within the relationship. In turn, Mayall (2002) suggests that power relations exist between the researcher and the child, although arguably these exist throughout society. Power relations, however, cannot be ignored and are inherent in relationships between adults and children, and researchers need to acknowledge that children remain subordinate to adults (Mayall, 2002).

I provided the college students with some background to my career, emphasising that I was still a registered children's nurse but now I taught at Salford University in my role as a lecturer. I described the study, showed them a brief video on YouTube®[8] that provides a quick overview of the simulation facilities and then showed them some of the things that the manikin could do (for example, breathing, fitting and vocal sounds). After this, they had the opportunity to ask me questions, and there were quite a few: for example, how long would the study run for, could they include this on their CVs, how many days were they required for. Such questions I had anticipated, and, although I answered verbally, the details were reinforced on the participant information sheet. At the end of this meeting I asked for a show of hands to gauge potential interest, and 25 students raised their hands (out of 27). They were all given a participant information sheet before I concluded the meeting. If they were

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[8] https://youtu.be/XNYA4F19GyU

interested in participating, they were asked to give their names to Diane within 48 hours. Several of the students talked to me individually at the end, and their enthusiasm about the study was more than pleasing. Schafer and Yarwood (2008) discuss the motives of young people for participating in a research project as being curiosity, learning how to use new equipment, interest in the research topic and vocational preparation. All these reasons seemed applicable to the project that I had introduced to them. Interestingly, remuneration was not discussed with the young participants when I first met them. Participation Works (2009) suggest that a reward should be provided so that young people feel appreciated, not exploited, and it encourages further involvement. For the level of participation involved in this study Participation Works (2009) suggest a gift voucher for £15 and certification. The decision to reward the young people was reviewed later, and they were presented with a £20 gift voucher and a certificate; however, they were not notified about this until the research had been conducted. Within 48 hours Diane contacted me to inform me that she had 19 students who wanted to participate but she only supported the participation of 15. Green (2013) suggests that researchers may not always have control over the individuals who choose to participate, particularly if recruitment is achieved by volunteer sampling or through gatekeepers. However, this was a sufficient number of participants to recruit, as it meant that there would be enough participants for the study to continue even if some were no longer able to or wish to participate. McLaughlin (2005) identifies that when recruiting young people as co-researchers it is favourable to over-recruit, as the lives of young people are unpredictable and the likelihood of them moving on is high. Although McLaughlin's work discusses young people as co-researchers, the same degree of fluidity could apply to young people as research participants.

A visit two weeks later was arranged to return to the college to get the participation consent forms signed and to discuss the arrangements of the first visit to the University. Once I had recruited the young people, they would be referred to as young participants throughout the duration of the study.

3.9   Data collection

Data was collected in the debriefings and interviews. Following collection, data was analysed from the recordings of the debriefings and interviews with the young participants, student nurses and lecturers.

3.9.1 The debriefings

Collecting data from the debriefings was considered an important part of this study. In keeping with my philosophical standpoint, I wanted to privilege the perspectives of the young participants and understand more about the impact of their involvement, which included their participation in the debriefings. I was aware that some of the content during the debriefings might not be relevant to the research aims and objectives as the usual practice of a debriefing is to address the clinical aspects of the scenario. However, as the young participants were providing their feedback to the student nurses, I considered that there could be some discussion relating to the involvement of the young participants.

Following the HFS sessions, the young participants contributed in the debriefings, which were tape-recorded. A debriefing presents the opportunity to nurture reflective, critical thinking and, moreover, supports the notion of 'thinking in action' and 'thinking on action' (Schon, 1983). Dreifuerst (2009) proposes that a debriefing draws out student thinking and assists in the development of complex decision-making skills. The provision of feedback is widely recognised as an intrinsic component of the debriefing process (Cant & Cooper, 2011; Dreifuerst, 2009; Fanning & Gaba, 2007; Hunt, Mininni & DeVita, 2008; Issenberg et al., 2005; Jeffries, 2005; Szyld & Rudolph, 2013). Hunt et al. (2008) identify that feedback usually occurs after the simulation session during the debriefing so that the scenario can run without any interruptions.

The debriefings were conducted as they usually would be, with the facilitator starting off the discussion; however, the young participants were asked to give feedback to the student nurses regarding what they had observed using the feedback tool they had devised. Therefore, the young participants provided their feedback as an addition to the usual processes of debriefing. The recordings from the debriefings were included as part of the data collection and were analysed alongside the interviews.

3.9.2 Interviews with the young participants

In-depth interviewing is one of the most commonly identified methods of collecting qualitative data (Green & Thorogood, 2009; Mason, 2018; Polit and Beck, 2014).

Denzin and Lincoln (2000) explain that interviewing is one of the most powerful ways to understand other human beings. The overarching aim of a qualitative interview is to elicit the views, opinions and experiences of an individual (Polgar & Thomas, 2013). This was in accordance with my philosophical standpoint as conducting interviews would enable the participants to provide me with their subjective views and perspectives. Interviews can be an intricate, time-consuming and tiring task to perform, as opposed to using a structured questionnaire, for instance (Mason, 2018). On the other hand, Silverman (2011) affirms that, in relation to other methods, the time and resources required to conduct interviews are comparatively economical, which I found to be typical of the interviews that I conducted.

The term 'qualitative interview' is somewhat expansive and incorporates a variety of different types of interviews. Authors differentiate between three different types of interviews, namely, standardised (or structured), semi-structured and unstructured interviews (Denzin & Lincoln, 2011; Polit & Beck, 2014). I chose to use semi-structured interviews with the young participants, as a structured approach might not have generated the data required and would have limited their ability to share their own perspectives. Lambert et al (2013) emphasised the importance of enabling children to have some control over what is addressed in an interview whilst still covering subjects pertinent to the research question. Using semi-structured interviews was in keeping with my philosophical standpoint and provided the young participants with the choices to discuss what was important to them. As recognised by Polit and Beck (2014), a semi-structured interview is used when the researcher has a list of topic areas that they wish to cover. I drafted some open-ended questions for the interviews (Appendix 5), which were based on my research objectives; however, the young participants were encouraged to talk openly about any aspect of the research study that they felt was pertinent. In turn, I found that I developed the interview questions intuitively and spontaneously on the basis of the responses from the participants.

In line with the aims and objectives of the study, I explored how they felt and what they thought about being involved in the planning and delivery of a simulation session and giving feedback to the student nurses. In accordance with the theoretical framework, it was important that I listened to the voices of the young participants and privileged their perspectives. The interviews enabled the young participants to

verbally express their views whilst at the same time providing me with the opportunity to explore any issues that arose. They were given the option to undertake the interview individually or in small groups and were asked where they would like the interviews to take place. O'Kane (2000) advocates, giving children and young people the choice of when, where and how an interview takes place is paramount in maintaining trust and respect. The young participants said that they would prefer to be interviewed in groups of twos or threes and to undertake this at their college. It was important that I respected their preferences and as such, their choices were adhered to. Further, Shaw, Brady and Davey (2011) identify that being interviewed with others can mitigate the power imbalance and encourage children and young people to be more open and honest with their responses. They chose who they wanted to be interviewed with and organised themselves into one dyad and three triads. Again, their preferences on who to be interviewed with was important. I wanted to ensure that the young participants felt comfortable and supported by their peers. Kellet and Ding (2004) recognise that peers are able to support each other but also can be cruel to each other. Thus, I ensured that they all agreed on the dyad and trio groupings prior to commencing the interviews.

I arranged for the interviews to take place on two consecutive days. There was one young person (Tara) who was absent from college on the day that I had arranged the interviews for. I attempted several times to rearrange the interview, but this was not possible due her college commitments and further absences. I did not pursue this too much as I was aware that perhaps she may not want to participate in the interview and my persistence may have led to her feeling obliged to participate.

In keeping with Tod (2010), I was aware that it is important that interviewees feel relaxed and comfortable and are focused, and the choice of environment would help achieve this. I asked Diane if she could arrange for a private, quiet space within the college to conduct the interviews, which O'Kane (2000) agrees is the most conducive environment for a productive research meeting. However, for three of the interviews I was taken to a classroom, and, although it was empty, there were college students looking through the window continuously. I felt that this was distracting for the young participants and this may have impacted on the young participants responses during the interviews. Byrne (2012) identifies interviewing teenagers in a classroom may provoke different responses from those given if the interviews had been conducted

in a café, for example. As a result, after I had conducted the first interview I placed a 'do not disturb' note on the door and changed the seating arrangements so that the young participants were not facing the door.

Prior to commencing the interviews, I asked the young participants if they were still happy to continue with the study to ensure that consent was still given. France (2004) identifies that it is good practice to continually review consent to confirm that young people remain willing to be involved. All of the young participants stated that they were still happy to participate in the interviews. I was also aware that during the interviews the young participants could discuss or raise issues which might be distressing for them. Therefore, I ensured that Diane was available should any of the young participants become distressed or upset during the interviews. Leegard, Keegan and Ward (2003) identify that the researcher must recognise that even if the interview is not anticipated to address a sensitive topic, any aspect of the discussion could trigger an emotional response. As such, the researcher needs to be vigilant and observe for changes in participant's body language, facial expressions and tone of voice. However, this did not occur during any of the interviews, but I emphasised that they could contact me at any time if they wanted to discuss any issues or concerns which arose after I had completed the interviews.

The role of the researcher is to encourage the participant to talk openly (Polit & Beck, 2014), yet they should be able to return the participant to the focus of the interview if they have deviated somewhat (Priest & Roberts, 2010). Byrne (2012) recognises that interviewing is a skilled process, and, in agreement with Bryman (2012), the prospect of conducting my first interview was daunting. However, as I became more familiar with the process, I found that these feelings subsided.

Green and Thorogood (2009) recognise that in interviews even though the interviewer and interviewee may speak the same language, this does not eliminate issues associated with what is said in the interview. In my role as an adult researcher I was aware that there could be a perceived unequal power relationship during the interviews. Hopkins (2010) suggests that children and young people may sometimes tell the adult researcher what they think they want to hear. However, I had been working with the young participants for several months before the interviews and I felt I had developed a trusting and open relationship with them. Furthermore,

throughout the preparation programme I had emphasised the importance of their involvement and they had been actively participating in developing the scenario and feedback tool. Therefore, when I conducted the interviews, I hoped that I had established a good rapport with the young participants and that they were able to provide honest answers.

At times I found the interviews quite testing, as the respondents were providing short answers to my questions. Similar findings were reported by Lambert et al (2013) who said that some of the children in their study responded with monosyllabic answers. Legard, et al (2003) suggest that a researcher needs to develop interview questions which are designed to facilitate a full answer, but not influence their answers. Thus, I was aware that in order to answer the research questions I needed to extract more information from them without providing too many leading questions.

The first three interviews that I conducted all lasted between 16 and 18 minutes, whilst the last interview lasted 26 minutes (see table 3.6). Sarah, Louise and Jenny were on the nursing cadets' course and I noticed that their responses were more comprehensive. Perhaps this was because they had experience of nursing and were able to provide more detail and context to their responses.

Table 3.6:   Duration of interviews with young participants

Young participant interviews (names)	Length (minutes: seconds)
Heather, Holly and Lexy	18:09
Chelsea and Amelia	16:00
Gina and Melissa	17:44
Sarah, Louise and Jenny	26:00

3.9.3 Focus group interviews with the student nurses

Focus group interviews with the student nurses were chosen in order to gain the subjective insights into a shared experience, such an approach was congruent with my philosophical standpoint. The aim of the focus group was to explore the perspectives of the student nurses about what worked well with the simulation and to gain insight into their views concerning the young participants' contributions. Further advantages of focus groups are that data can be obtained swiftly and

economically and participants may feel more at ease discussing their views in a group of people who have experienced similar situations rather than in an individual interview.

Whereas some authors suggest that a focus group should consist of no more than six to eight people who have a shared interest or characteristic (Ritchie & Lewis, 2003; Silverman, 2011), others propose that it is acceptable to have up to 12 participants (Green, 2007). Holloway and Wheeler (2002) support this by identifying that a group must be large enough to allow a range of perspectives but if too many participants are involved the discussion can become fragmented and disorderly. In turn, Green and Thorogood (2009) recognise that group dynamics can have a negative impact on the development of a discussion in that individuals may become marginalised if they feel inhibited and not able to talk freely. I was aware that my role as the researcher was to ensure that all participants contributed, and I was able to draw the participants in to the discussions when I felt that they were not involved. Robson and McCartan (2016) state that the role of the researcher is to ensure that the group runs effectively but needs to find a balance between a passive and active role. On reflection, I realised that I had been required to do this on several occasions as I directed some of the questions to individuals in order to draw them in to the discussion. In agreement with Goodman and Evans (2010), I had been required to encourage participation.

The limitations, however, of focus groups involve recording the data collected in order to differentiate between individual speakers and how to transcribe words when two or more participants are speaking at the same time. In order to overcome this, ground rules about speaking one at a time were established before the discussions commenced. The student nurses were organised into groups of five or six participants with those whom they had a shared experience with, which is an important consideration when arranging focus group interviews. It was expected that such numbers would provide a diversity of views whilst still ensuring that everyone was able to express their thoughts. This, however, proved to be a challenging aspect of this study, as almost half the student nurses did not attend the focus group interviews on the days that they were arranged for. This was disappointing and frustrating, as I had planned the interviews in between their timetabled sessions and

ensured that they did not have to attend on a day when they were not scheduled to be in the University. Nevertheless, I conducted three focus group discussions with five, four and three participants, respectively. I managed to rearrange one more of the focus groups (with three participants), and thus, in total, 15 of the student nurses attended the focus group interviews (see table 3.7). I contacted the other six students on several occasions and tried to rearrange the dates, but this was not successful. However, they all provided different reasons for not attending: four had been required to take an interruption in their studies as a result of failing assessments, one was on maternity leave and the other had personal issues and did not feel able to attend. Although I cannot be certain, this may have had an impact on the results of my study, as the perspectives of almost a third of the student participants were not forthcoming.

Table 3.7: Duration of interviews with student nurse participants

Student nurse participants	Length (minutes: seconds)
Julie, Claire, Sandra, Mandy and Leona	42:13
Bridgit, Florence, Jackie and Nicola	26:23
Ameera, Andrea and Heidi	31:57
Belinda, Sajeeda and Paula	32:38

During the focus groups I explored what the students liked or disliked about the experience in relation to being observed and given feedback by the young participants and their perspectives on how, if at all, the experience would have an impact on their learning and future practice (see Appendix 6).

3.9.4 Interviews with the lecturers

The lecturers involved in the simulation sessions were invited to participate in individual semi-structured face-to-face interviews. The interview question guide was different from that used for the student nurses and young participants (Appendix 7). In congruence with the interpretive approach I adopted for this work, the interviews explored what, if any, differences were perceived in students' performance in comparison with their previous experiences of facilitating simulation as a result of the young participants' involvement. The lecturers were also asked whether they

thought the students engaged to a greater or lesser degree with the addition of the young participants observing. The aim was to establish their perspectives on whether the young participants' involvement in simulation had a positive or negative impact on the students' learning experience. The interviews with the lecturers were conducted separately and varied in their duration (Table 3.8).

Table 3.8:   Duration of interviews with lecturer participants

Lecturer participants	Length (minutes: seconds)
Sam	30:50
Danny	23:45
Pat	21:08
Chris	21:24
Jerry	7:58

3.10   Data analysis

For this study, I chose to analyse the data using the framework approach as described by Ritchie and Lewis (2003). Smith and Firth (2011) propose that framework is a useful approach for the novice researcher as it assists with the development of more advanced data analysis skills that are required for robust qualitative research. Initially developed during the 1980s at the National Centre for Social Research to analyse policy research (Ritchie & Lewis, 1994), the framework approach is now used extensively by qualitative researchers. Analysing qualitative data is a complex process often involving an immense amount of data, which can result in the researcher losing focus (O'Leary, 2017) and can lack transparency (Ward et al., 2013). Ritchie and Lewis (2003) claim that often data analysis methods are not always clear in research papers; however, adopting the framework technique enables the process of data analysis to be transparent and explicit. In addition, it was imperative for this study that there was a clear audit trail of data analysis and that the process I used was systematic and rigorous.

Pope et al. (2000) identify that qualitative data analysis can be undertaken using either an inductive or a deductive approach. The inductive method comprises a

gradual approach in generating themes/categories in response to the data, whereas a deductive approach concerns the testing of a hypothesis (Gray, 2014). In keeping with the epistemological position I adopted for this work and the aims of the research, it was necessary that I used an inductive approach to data analysis.

Ritchie and Spencer (1994) suggest that the main aim of framework analysis is to describe and interpret what is happening in a specific setting, which was in keeping with the interpretive approach which I had adopted for this study. Pope et al. (2000) criticise the framework approach, due to the identification of a thematic framework at the beginning of the analysis stage. However, Ritchie and Spencer (1994) advise that the thematic framework is constructed from the research aims and objectives and initial themes identified in the familiarisation stage of analysis. For my study, although a thematic framework had been created at the beginning of data analysis, an iterative approach was adopted. This iterative process was essential to the creativity of the analysis and development of ideas, clarifying meanings and reworking concepts as new insights emerged from the data. Another significant reason for choosing the framework approach was that it assists with the management of large quantities of data. As I had interviews with three different data sets (young participants, student nurses and lecturers), being able to move back and forth across these data sets inductively was very useful during the data analysis stage.

Ritchie, Spencer and O'Connor (2003) describe three key stages of the framework approach:

1. **Data management** – this involves familiarisation with the data: identifying initial themes/categories, labelling and tagging the data, developing a coding matrix and assigning data to themes

2. **Descriptive accounts** – summarising and synthesising the coded data by refinement of the initial themes, identifying links between the themes until the whole picture emerges and the development of further abstract concepts

3. **Explanatory accounts** – developed at a later stage, derived from finding patterns or building explanations from other evidence or interrogations of the data

In keeping with Smith and Firth (2011), I found that I developed my data analysis skills considerably, although I initially found some of the stages confusing, especially as a variety of terms were incorporated into these stages. Ritchie et al. (2003) explain that the framework approach facilitates systematic organisation of the data and allows the researcher to move back and forth between the various stages of abstraction without overlooking any of the raw data. Furthermore, Silverman (2010) adds that this process helps to ensure that findings are not anticipated and themes are not generated prematurely.

The three stages described by Ritchie and Spencer (2003) were not followed in a consecutive manner; rather, each stage was started until I was satisfied that the data were analysed fully, then the process was continuously iterative and moving back and forth between each of the stages occurred until I was satisfied that the themes were stable. The whole process of data analysis took longer than anticipated (18 months), but as a result I felt confident that my concepts and themes were fixed.

The terminology used in qualitative data analysis can be confusing and initially daunting to the novice researcher. In keeping with the many approaches to qualitative data analysis, various terms are used interchangeably, for example, codes, themes and concepts. The terms used in this study are defined below and represent each stage of data analysis. Figure 3.4 shows how these are interconnected and developed from initial themes to concepts.

i) **Initial themes** – how the data were labelled initially during the familiarisation stage

ii) **Codes** – these are labels or tags assigned to a unit of data (key words or phrases)

iii) **Categories** – folders that contain codes about the same subject and remain close to the participants' words

iv) **Themes** – categories that are interlinked

v) **Concepts** – ideas that link the themes together

Figure 3.5:   How each of the terms are linked to one another

| Initial themes (what is going on) | Codes (in vivo - assigned to all text) | Categories Linking codes together | Themes Linking categories together | Concepts Linking themes and generating core concepts |
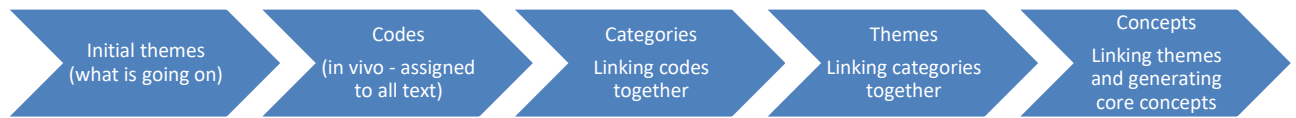
3.10.1 Transcription of the data

Initially, I had intended to transcribe all the interviews myself; however, after completing just one transcript in ten hours I realised this was immensely time-consuming. I had underestimated the amount of time this would take for a non-professional typist like myself, deducing that transcribing was not an efficient use of my time. Braun and Clarke (2013) advise that a researcher should plan that an hour of recorded digital data will take about eight hours to transcribe. Originally, I had interpreted that fully immersing myself in the data meant that I had to transcribe all the data. However, in retrospect I acknowledge that this is an unrealistic expectation, especially when there is a vast amount of data to be transcribed. In turn, as a part-time doctoral student with a demanding job, balancing work commitments and studying was a challenge and I had to ensure that I managed my time effectively.

3.11   Data management

3.11.1 Identification of initial themes

As with most qualitative data analysis, Ritchie et al. (2003) articulate that initial data management involves identifying the initial themes under which the data will be sorted, labelled and compared. This is a crucial part of data analysis, and the construction of a thematic framework is established. The first part of this phase of the framework approach involves being completely immersed in the data (Braun & Clarke, 2006; Smith & Firth, 2011). Ritchie et al. (2003) refer to this as building the 'foundations' of the thematic structure, and it is a fundamental aspect of the data analysis process. All the data were audio-recorded, and hence the first step was to familiarise myself with the data by listening to the recordings several times followed by reading and re-reading the transcripts. This iterative process enabled me to note down and highlight concepts that I believed were significant with regard to the

research aims and objectives. As I listened to and read the data over and over, I started to recognise certain patterns or similarities within the data. I was also aware that I could potentially overlook certain components of the data if I focused too much on the research objectives. Compte (2000) suggests that when analysing qualitative data researchers often only note the data that captivate them or that they can make sense of. Once the transcripts had been read and listened to several times, specific data sets were chosen for the identification of recurring initial themes; such themes would form the indexing chart. As Ritchie et al. (2003) suggest, it is important that a diverse range of data are selected for this process; therefore, interviews from a young participant group, student nurse group and a lecturer were chosen for this. I went through each of these interviews line by line to identify the initial themes. Table 3.9 illustrates an example of an extract of this process and shows some of the initial themes that were generated.

Table 3.9: **Example of initial themes from the data set**

Extract of interview with Chelsea (YP4)	Initial themes (notes made in the margins of transcript)
"*it was like our ideas…that made the character in the scenario as well. So that we got a part, we made the person as well, so that helped like, it gave us involvement, shall we say… like you took the ideas on and they took your ideas on, into account*"	Young person aware that their ideas were used to create the character in the scenario; Felt involved
"*It shows like how the university does things through the nursing and how like the different areas they go into and it just shows how good the university is*"	Insight into nursing and university
"*Yes, saying it'll help, obviously it's something extra, like some people won't have this on the UCAS form. Like the ones that have done this, that research, well you have something extra and it'll obviously look better and also like … it's also benefited me because obviously I wanted to do children's nursing. So, it's like benefited me as well because it shows children's nursing in a practice. And at a university as well*"	Benefit for the young person Added value UCAS forms Insight into children's nursing
Extract of interview with Sam (L1)	Initial themes (notes made in the margins of transcript)
"*…students do generally feel there's almost a higher anxiety factor when they are streaming, number one, so even though you help*"	Students are anxious when simulation is streamed

them differentiate between filming and keeping and live streaming, I think that does heighten their anxiety anyway"	(with people watching them)
"_So in the morning the voice person was less challenging, and the one in the afternoon, she pushed the students more. I felt that they were both authentic in the role that they were playing, so that was really good. I hadn't, again like I said, with it being new I just didn't know what to expect, I guess, and I thought their dialogue with the student really flowed. It didn't feel like they were looking for a script or whatever, it really felt authentic in exchange of dialogue as such, so that was nice. And obviously the age of the voice, which it just lent that tangibility to the scenario I think, so I think I was nicely impressed with actually what it brought to the simulation in a way_"	Young person was challenging Authentic in the role Didn't know what to expect from the young person Conversation flowed.Felt authentic. Age of the voice was tangible Surprised at the outcomes
Extract of interview transcript with Julie (StN1)	Initial themes (notes made in the margins of transcript)
"_Because I think it was good because we had our own conversations that we would naturally have in placement, like, you know, about watching telly and things. So it was nice because it felt more real because of the responses_"	Natural/realistic conversation Similar to practice
"_I was glad we knew a bit about, like that it was asthma because then I felt more like, well, I have dealt with these situations before in practice, so I felt more comfortable_"	Felt prepared Familiar situation to practice
Extract of debriefing transcript (Group 5)	Initial themes (notes made in the margins of transcript)
"_It seemed really realistic didn't it, the actual scenario itself, and that does happen on wards, children do deteriorate really quick, so that was really good_" (StN7 Florence)	Scenario was realistic Scenario comparable to practice
"_I tried not to be mean, I didn't know what to do because you were nervous and I didn't want to be mean_" (YP7 Melissa)	Worried about being unkind Knew the students were nervous

3.11.2 Coding and labelling of the data

Once the sample of data had been read and initial themes were identified, a coding matrix was formulated (Table 3.10). Following this, two experienced researchers,

Suzanne and Yvonne [pseudonyms] reviewed the coding matrix and the transcripts from which this was generated. Later, we reviewed the indices together and placed these on a mind map, identifying the links between the initial themes (see figure 3.6). In keeping with Mason (2002), pictorial diagrams or thematic maps can assist with data analysis as a means of understanding and constructing themes and subthemes.

Table 3.10: Coding matrix

Initial themes	Codes
1) Realistic scenario	1.1 Family and social history 1.2 Hobbies and interests 1.3 School 1.4 Different if lecturer had written it 1.5 Recognition that young person wrote the scenario
2) Realistic conversation with the manikin/young person	2.1 Conversations were natural/flowed 2.2 Context of conversation was real 2.3 Appropriate language used 2.4 Context of conversation different between lecturer and young person providing the voice of the manikin 2.5 Managing difficult/challenging conversations 2.6 Developing therapeutic relationship 2.7 Drawback of manikin: unable to display body language and unable to assess skin colour 2.8 Situation felt real
3) Student nurses feeling unsure and apprehensive	3.1 Student nurses feeling like they need to know everything and be prepared 3.2 Student nurses feeling nervous about the simulation due to lack of exposure/experience with simulation 3.3 Student nurses feeling anxious about being watched from another room 3.4 Student nurses feeling like they are being assessed 3.5 Student nurses feeling like they are being judged 3.6 Would act differently in practice
4) Young people feeling valued	4.1 Young people's involvement in writing the scenario 4.2 Young people's development of the feedback tool 4.3 Young person being the voice of the manikin 4.4 Young people being involved in the debriefings 4.5 Authentic feedback from young people in the debriefings 4.6 Young people given independence to write the scenario 4.7 Young people able to use their own words during the scenario 4.8 Young people felt nervous 4.9 Felt supported by academics/researcher 4.10 Observations of the student nurses 4.11 Using the feedback tool
5) Benefits of participation for young people	5.1 Insight into nursing 5.2 Insight into higher education 5.3 Meeting lecturers 5.4 Can use for UCAS applications 5.5 Developed confidence 5.6 Working in groups 5.7 Developed communication skill 5.8 Helping with research 5.9 Enjoyable/positive experience 5.10 Insight into simulated practice 5.11 Learn how to provide feedback through observation

	5.12 Reflect on own experiences
6) Learning for student nurses (in addition to learning due to 1 and 2)	6.1 Student nurses learned about asthma management 6.2 Student nurses developed communication skills 6.3 Teamwork
7) Power relations	7.1 Student nurses being observed by young(er) people 7.2 Cadets v mainstream students 7.3 Selecting specific young people to participate 7.4 Student nurses receiving feedback from/being observed by those less experienced 7.5 Young people not wanting to be critical 7.6 Curriculum leader's view of higher education

Figure 3.6: Mind map of initial themes

Smith and Firth (2011) suggest that the process of constructing a coding matrix is unwieldy and time-consuming. Computer-aided qualitative software packages exist to assist with this process and with data management. However, despite the benefits of using these, I wanted to undertake this process manually to further immerse myself in, and familiarise myself with, the data, especially as I had not transcribed these myself. In turn, Spencer, Ritchie and O'Connor (2003) advocate that computer-aided tools should only be used as analytical support and do not replace

the skilful role of the researcher in analysing and interpreting the data. The researcher is responsible for identifying and refining the emerging themes throughout the process of the framework approach (Pope et al., 2000). Once I was content with the codes attached to the indexing matrix, I began to work my way through the raw data and apply the codes to all of the data. Each line of the transcripts was read in detail and assigned a code. At times, some of the data had more than one code applied; this occurred where some of the themes overlapped and were interspersed in a large section of the data (Table 3.11).

Table 3.11:   Example of labelling the data

STUDENT NURSE	Data	Code
Researcher	But how did you feel the young person was as the voice of the manikin?	
Claire	Really good.	4.3
Mandy	I thought she was good.	4.3
Julie	Like after a couple of minutes I forgot that it was a manikin.	2.4
Mandy	Yeah, I did. I started to feel like it was real.	2.2
Claire	That's what I said. I actually was…really cared for this patient by the time I came out, I honestly thought she was real.	2.6
Julie	At first it was a bit strange and…but then because she was responding so naturally and like it was…it just felt natural after…	
Claire	It did feel very real.	2.1
Sandra	Because she was saying like real-life things as well.	2.1
Claire	Why are you doing this and can I go home now and…it was challenging to respond because you've just got to respond there and then, and usually you've got your mentor there and she'd kind of usually respond for you, do you know what I mean? But to have to do just think on the spot, at some point I was like…but it was good to like learn how to kind of deal with those situations.	2.5
Julie	Because I think it was good because we had our own conversations that we would naturally have in placement, like, you know, about watching telly and things. So it was nice because it felt more real because of the responses.	2.5/6.2 2.1
Researcher	Because if I was to do that voice, my responses might not be age-appropriate, you know, I'm far away now from 15. And I don't sound like a 15-year-old, you know. I think…would you say that sort of listening to a 15-year…you could tell the difference of whether it would be a 15-year-old or somebody older?	

Sandra	I think if it was like a lecturer that was speaking I don't feel like I'd be able to ask, 'Oh, did you watch X Factor at the weekend?', because it might not be something that you'd necessarily think that…you would ask a lecturer.	2.4

3.11.3 Sorting, summarising and synthesising the data

Once the data were assigned codes, they were sorted into thematic charts (see Figure 3.7). At this stage the thematic charts were discussed with the two researchers who had been involved in the initial stage of data analysis. Ritchie et al. (2003) state that the purpose of creating thematic charts is to enable the researcher to focus on each subject or theme one at a time in order to unravel the intricate details from the data. Each main theme and related subthemes were inserted into a thematic chart in columns, and each respondent was assigned a row. Once all the data had been transferred into thematic charts, the next stage of analysis was to summarise and synthesise the data. Here, it was essential that I remained true to the participants' words and retained enough context so that I did not have to revisit the raw data to clarify their meaning. Ritchie et al. (2003) propose that the data analyst must summarise the data appropriately and sensitively without losing content or context.

At times, the data management stage of framework analysis seemed an intense and lengthy process. However, repeatedly reading the transcripts, listening to the recordings, identifying initial themes, developing a coding matrix, labelling the data and producing thematic charts ensured that I was thoroughly familiar with the data. In turn, this iterative process enabled a clear audit trail and the process of data analysis was transparent and as such, adds rigour to the findings.

3.12   Descriptive accounts

In this stage, descriptive analysis of the data occurs, which involves untangling the nature and content of a particular theme. Ritchie et al. (2003) explain that there are three stages to this process, namely, detection, categorisation and classification.

Figure 3.7:   Example of a thematic chart

3.12.1 Detection

Here, all the initial themes were examined across all the data sets, and the ranges of views and perceptions that were labelled within the themes were noted. Once the ranges were identified, I then set out to sift and refine these labels into broader categories, which led on to the next stage, namely, categorisation.

3.12.2 Categorisation

Several categories were identified, and I looked to see if there were connections or associations between these categories. It was at this point that the higher levels of abstraction occurred. I began to move away from the actual words of the participants into a more abstract way of considering the data (see Table 3.12). Ritchie et al. (2003) state that although in this stage the analyst is moving away from using the language of the participants, the analysis should not lose the overall context. At this stage, my interpretations of the data were discussed, negotiated and refined with Suzanne and Yvonne and as experienced researchers, they helped me to interpret the findings in a more abstract way.

Table 3.12: Example of identifying categories

Initial themes	Codes/labels	Refined categories and links to initial themes
1) Realistic scenario	1.1 Family and social history 1.2 Hobbies and interests 1.3 School 1.4 Different if lecturer had written it 1.5 Recognition that young person wrote the scenario	**Background and context of scenario realistic**
2) Realistic conversation with the manikin/young person	2.1 Conversations were natural/flowed 2.2 Context of conversation was real 2.3 Appropriate language used 2.4 Context of conversation different between lecturer and young person providing the voice of the manikin 2.5 Managing difficult/challenging conversations 2.6 Developing therapeutic relationship 2.7 Drawback of manikin: unable to display body language and unable to assess skin colour 2.8 Situation felt real	**Words, tone of voice and conversation were realistic** **Learnt how to manage a challenging conversation** **Able to develop rapport with the young person/manikin**

3.12.3 Classification

The final stage in developing the descriptive accounts involves further refinement of the themes and generating even broader abstract concepts. I adopted an iterative approach, moving between labels, categories, themes and concepts until I was satisfied that the themes and concepts were stable, whilst ensuring that I remained true to the original data (see Table 3.13).

Table 3.13: Example of linking codes, initial themes, themes and concepts

Initial themes	Codes/labels	Refined categories	Themes	Concept
3) Realistic scenario	1.1 Family and social history	Background and context of	**Realism of the scenario**	

				A
	1.2 Hobbies and interests	scenario realistic		U
	1.3 School			T
	1.4 Different if lecturer had written it			H
				E
	1.5 Recognition that young person wrote the scenario			N
				T
4) Realistic conversation with the manikin/young person	2.1 Conversations were natural/flowed	Words, tone of voice and conversation were realistic	**'Being' the voice**	I C
	2.2 Context of conversation was real			R
	2.3 Appropriate language used			E
	2.4 Context of conversation different between lecturer and young person providing the voice of the manikin			A L I T
	2.5 Managing difficult/challenging conversations	Learnt how to manage a challenging conversation	**Learning from difficult situations**	Y
	2.6 Developing therapeutic relationship	Able to develop rapport with the young person/manikin	**Learning to build relationships**	
	2.7 Drawback of manikin: unable to display body language and unable to assess skin colour			
	2.8 Situation felt real			

3.13 Explanatory accounts

The final stage of data analysis in the framework approach is the development of explanatory accounts from the descriptive accounts. This involves being able to progress the analysis from the descriptive accounts to an even deeper level (Spencer et al., 2003). This incorporates explaining the findings, looking for associations between and across the final concepts and providing an explanation of

why these patterns are occurring. The findings were further considered by establishing relationships between the final concepts.

3.14 Rigor

There is a consensus that qualitative research should be undertaken using rigorous processes and significant consideration must be given to the potential for bias during data collection, analysis and reporting of findings (Rolfe, 2006; Tobin & Begley, 2004). Further, Rettke, Pretto, Spichiger, Frei & Spirig (2018) propose that demonstrating methodological rigor can be challenging in qualitative research, especially when large amounts of data are generated and analysed using a specific approach. Holloway and Wheeler (2002) suggest that the quality of a research study should be described in terms of its credibility, trustworthiness and transparency. Lincoln and Guba (1985) who first emphasised the notion of trustworthiness to assess the quality of research. Furthermore, Lincoln and Guba (1985) suggested that in order to judge the trustworthiness of qualitative research, the concepts of transferability, credibility, dependability and confirmability should be considered. These concepts will be applied to this study and thus demonstrate how the research was undertaken using a rigorous approach.

Transferability relates to how the research can be applied to another setting, population, situation or time. and relies on the researcher providing a clear context for the research. In this chapter I provide a detailed account of how and where data was collected and in Chapter 4, there is a comprehensive account of the preparation programme. In this study, the preparation programme that was undertaken with the young people could be used in other HEI's when involving children and young people in simulation and co-producing simulation sessions. This is discussed further in Chapter 9 as part of the recommendations.

Using verbatim quotes when reporting the findings enhances the credibility of the research. Throughout chapters 5, 6 and 7 I integrate verbatim quotes from all of the participants in order to provide a representation of their perspectives and insight into the basis of the findings from the analysis. This helps to ensure that the reported findings are grounded in the data. Further, credibility was strengthened through the challenges presented by the supervisory team during data analysis. This was an

iterative process, with the supervisory team being involved in all stages of the data analysis process.

Lincoln and Guba (1985) explain that dependability concerns the awareness of the researcher to accept that the research has been conducted from a specific standpoint, by a researcher with particular skills and in a specific environment, all of which will influence the study. Rolfe (2006) suggests that reflexivity relates to the thoughts and actions of the researcher during the research process. In keeping with Rolfe, I adopted a reflexive approach throughout the study and this is evidenced in this thesis as I provide continual rational and justification for the decisions made during the study. For example, the rational for choice of data collection methods is discussed earlier in this chapter. Further, in chapter 4 I discuss how I adapted the way that I worked with the young participants based on the first sessions and encounters I had with them.

Provision of a clear audit trail throughout a research study is a vital part of all rigorous research studies (Streubert & Carpenter, 2011). Further, a clear audit trail assists with establishing confirmability of the data and findings (Rolfe, 2006). In accordance with Rolfe, a transparent audit trail was evident in the research design stages, for example in relation to the research questions and sampling methods adopted. Further, a rationale for the data collection methods used and use of the framework approach has been provided. The detailed application of the framework approach provided a clear audit trail of the processes undertaken to analyse the data and are identified clearly in this chapter.

3.14   Presentation of findings

Unlike reporting findings from quantitative data, qualitative data can be presented in numerous ways and can provide the researcher with a number of challenges. Notwithstanding, it is essential that the findings are presented in a coherent and clear manner so that the reader is guided through the findings logically and can make sense of what they are reading (Rubin & Rubin, 1995; White, Woodfield & Ritchie, 2003). It was also imperative to present the findings in a way that would remain true to the participants' words. When reporting the findings, it can be tempting to incorporate lots of verbatim quotations (White et al., 2003). Although direct extracts contextualise the findings and add credibility, it is recommended to use verbatim

phrases sparingly and with good judgement (Holloway & Wheeler, 2002). The citations from the participants have been used judiciously, and consideration has been afforded to all the participants.

As discussed earlier, through the application of framework analysis I identified three main concepts: meaningful involvement, creating a more authentic reality and uncertainty with themes identified within each of the concepts (see table 3.13).Therefore, it seemed logical to me to present a chapter for each of these concepts (Chapters 5, 6 and 7), and I included my interpretations, with some aspects supported by the literature. Chapter 8 provides a discussion of the findings, which relate to the explanatory accounts, with a deeper level of abstraction and identifying relationships between the concepts (Spencer et al., 2003).

Table 3.14:   Final themes and concepts following data analysis

THEMES	CONCEPT
Finding voice Developing voice Sharing voice Challenging voice Personal development	**Meaningful involvement**
Realism of simulation scenarios Being the voice Learning to build relationships Learning from difficult situations	**Creating a more authentic reality**
Unfamiliarity Being prepared Being watched Being assessed Shifting relationships	**Uncertainty**

Chapter 4

The preparation programme for the young participants

4.1   Introduction

This chapter provides a detailed account and critical insight into the training and development programme that was provided for the young participants prior to the HFS sessions with the student nurses. An overview of the training days is provided in chapter 3 (table 3.2). What follows is a comprehensive and reflective discussion of my experiences of working with the young participants and the rationale for the decisions made regarding the methods used to prepare them to write the scenario and be involved in the HFS sessions.

4.2   Preparation programme (Day 1)

In preparation for Day 1, I had developed a detailed session plan (see Appendix 8); although this was structured, I recognised that I had to be flexible. I had negotiated with Diane and the young participants to start the day at 9.00am. Diane had explained that the young participants were used to starting their college day at 9.00 and she suggested that this should remain the same for my study. I was expecting 15 young people. On arrival, Diane explained that she had decided to withdraw two students from the study as they had contacted her in the morning, stating that they '*couldn't be bothered*' to turn up on the first day. Two other students were unable to attend as they had an English exam that day, but Diane explained that they would attend the next sessions. When working with young people, it is inevitable that they will have other priorities and may not be able to commit themselves 100% to a study. I explained to Diane that those sitting the examination could still participate in the study and that I would spend some additional time with them on their next visit to orientate them to the simulation room and manikins.

4.2.1   Welcome and introductions

Diane informed me that some of the young participants did not know each other as they were on different courses. Eight of the young participants were studying the

health and social care vocational course and three were on the NHS nursing cadets' course. It was not until I was some way through the research that I recognised that there were differences between the two groups. I later came to understand that some of the health and social care vocational students were on a mainstream programme, whereas others were enrolled on the more prestigious cadets' programme.

Therefore, to start the day off we did some introductions. We started the day in a classroom so that I could gradually orientate the young participants to the simulation environment and manikins. This was in the event that any of the young participants might feel uncomfortable or anxious about being around the manikins; as noted in Chapter 3 (Section 3.15.3), manikins can be frightening for some people. As this was the first day of working with the young participants, I was nervous that they might not engage with me or even want to be there. Therefore, in accordance with Shaw, Brady and Davey (2011), I welcomed the young participants in a comfortable environment with seating arranged in a circle, with refreshments available on their arrival. I was reassured that my supervisor was able to be present for the first hour, as she has considerable experience of working with young people. Issues regarding housekeeping were discussed and I ran through the plan for the first day. It was important that I explained what the aims and outcomes were for the day and that they were able to ask any questions. I emphasised that if they felt uncomfortable at any point or did not wish to continue with the study they could withdraw at any time.

4.2.2 Orientation to the manikins and simulation environment (Day 1)

Following the introductions, I orientated the young participants to the simulation environment and manikins. I wanted the young participants to be able to spend at least one hour (longer if they wanted) touching and interacting with the manikins. I showed them various physiological changes that the manikins could simulate, including seizures and central cyanosis, and invited them to listen to normal and altered chest sounds. However, I presented this using non-technical language, for example, I explained it in terms of fitting, going 'blue' when cold or unwell or sounding a bit wheezy. The young participants all seemed to understand that people can experience such physiological changes and were interested to see that the manikins could simulate this. This less formal and different approach seemed to engage the young participants and facilitated greater discussion and interaction with me. In

agreement with Street (2015), reflecting on her work with young research advisors for the NCB, having a mixture of activities is important when working with young people in order to maintain interest. In turn, I encouraged them to operate the manikins, provide the voice and talk to them. The young participants had been quiet to start with, but after this activity they appeared much more relaxed and seemed comfortable talking to me and each other. This was perhaps perceived as a fun and interactive activity as opposed to the more formal procedure of introductions within a group.

4.2.3 The young participants meeting the student nurses (Day 1)

For the next part of the day I arranged for the young participants to meet with the student nurses. I asked the young participants if they felt comfortable with this, and they all said that they did. I thought it was important that they met each other before the day of the HFS session to ease nerves and become familiar with each other.

Before I brought the young participants into the classroom where the student nurses were, I started with a further explanation to the student nurses about the study. Prior to this they had received a participant recruitment notice on the virtual learning environment from the programme leader, and in the morning I had left some participant information sheets with the module leader. They had read the sheets but still required clarification about what the study entailed. I explained that they had 48 hours to decide whether they wanted to participate, or they could sign the consent forms on that day. At that time 32 students were registered on the module, and 25 agreed to participate on the day and signed the consent forms. I returned to the group after 48 hours to see if any other students wished to participate, but this was not the case.

The student nurses had been in a teaching session. The room that they were in was a flat, fixed-seating lecture theatre, and, although the seating could not be rearranged, the large capacity of the room meant that there were plenty of seats. However, in retrospect it would have been preferable to have had the tables and chairs in small groups so that the participants could move around more freely. As most of the young participants were planning to apply for a nursing programme, it was a good opportunity for them to be able to ask the student nurses questions. The questions focused mainly on the programme content, placements, assessments and

having a part-time job. One young participant asked the student nurses if there was anything that they could have done differently at college/school in preparation for university. The student nurses suggested that they needed to be organised, work hard and practise referencing. They also asserted that they needed to understand that there is so much support at college and, although the University is supportive, you are an adult learner and in essence 'in charge' of your own learning. It was pleasing as some of the student nurses had themselves attended the same sixth form college and knew Diane, so they came and talked directly to her and the young participants. On reflection, I could have invited some of the student nurses to the college to meet and talk to the young participants.

4.2.4 Demonstration of an HFS simulation session (Day 1)

After lunch, I demonstrated how the manikins are used in an HFS simulation session. The simulation involved the assessment of a 4-month-old (infant manikin) with bronchiolitis who had subcostal recession, an increased respiratory rate and an oxygen saturation of 88% in air. The young participants observed me role-playing a student nurse carrying out an assessment of the infant, and then we did a short debriefing and they were invited to discuss the simulation with me. The young participants appeared intrigued and enthusiastic about the use of the manikins, and I think this helped them to be motivated and to return for Day 2.

4.2.5 Seeking the views of the young participants about what makes a good nurse (Day 1)

The last part of the day was concerned with asking the young participants about their experiences of healthcare and what they considered to be important when being cared for either in hospital or in a community setting. This could be related directly to their experiences as a patient or from their experiences of seeing other family members who were hospitalised. However, I asked them to be specific about what values they thought a nurse should possess who would be caring for children and young people and what they thought makes a good nurse. The purpose of this activity was to seek their views as a starting point for devising the feedback tool that they would use during the debriefings with the student nurses. Initially, I had planned this to be a group work activity, but I noticed that several of the young participants looked tired (it was 2.30pm) and were yawning. In agreement with Shaw, Brady and

Davey (2011), it was important that I was able to maintain the interest and engagement of the young participants within the study. As Shaw, Brady and Davey (2011) point out, it is advisable not to make unreasonable demands on the time of young people, and therefore I quickly reconsidered the group work activity. Instead I asked them to write down their thoughts about the values on a Post-it note (I gave them two each) and explained that we would discuss these in more detail the next time we met.

To close the day, I asked the young participants if they had any questions or concerns regarding the study and whether they were all still happy to participate. None of the young participants stated that they wished to withdraw at this point, nor did they raise any further questions. At the next visit they would be writing the scenario, and I asked them to think about and perhaps explore asthma in young people. This was followed up the next day by their tutor.

The next session was planned for five weeks later. Running the next day with such a long gap in between was not ideal, and I was concerned about attrition; however, there were several reasons for this time lapse. The young participants were all in college only on the Monday and Tuesday of each week, they had one week's holiday and for each Monday and Tuesday prior to the second day I had existing teaching commitments. My concerns regarding attrition were not unfounded, as two of the young people did not return for the second day; however, the two who had missed the first day owing to exams did attend, which meant there were still 11 participants.

4.3   Preparation programme (Day 2)

The second training day with the young participants took place five weeks after the initial orientation/training day. I asked the young participants if they were all still happy to continue with the study and verbal consent was confirmed by all the young participants. On arrival, the young participants were provided with a plan of the day. This time, I had planned for the day to finish at 3.15, as on the first day it was recognised that the young people became tired and engaged less after 2.30pm. Diane agreed that the young participants do become lethargic and lose interest after lunch and agreed that the session should finish earlier.

The classroom was organised in preparation for group work, and the young participants chose where they sat. Initially, six chairs were provided at each group table. This ensured that no one felt obliged to sit with people unfamiliar to them or who they did not have a particularly good relationship with. It was essential that the young participants felt relaxed and confident to express their views and opinions freely. In concordance with Fallon et al. (2008), it was important that I engaged with the young participants in a safe environment so that they felt comfortable and were able to speak openly. This was particularly important as there were four facilitators (me, two lecturers and a tutor from the college) and therefore there was a potential for the young participants to feel intimidated, and it was paramount that they did not feel subordinate in any way (John, 2003). Hopkins (2010) identifies that a young person may be susceptible to the unequal power relationship in research and often endeavour to please the adult, rather than oppose them. For me, it was essential that the young participants did not feel this way, and I constantly encouraged them to be open and honest with me.

In order to provide a more informal environment, refreshments and snacks were available all day and music was played in the background. Eleven young participants arrived for Day 2, accompanied this time by a different tutor (pseudonym Kirsty). Two young participants were present on Day 2 who had not been able to attend the first day owing to exams, and two participants from Day 1 did not attend. It was important that a summary of the previous training day was provided, not only for the newcomers but also as a recap for those who were there, as it was five weeks since the first day of training.

4.3.1 Reviewing the Post-it note exercise (Day 2)

The aim of the first exercise was to follow on from the 'Post-it' exercise on the first day, in which the young participants had been asked to write down what values they thought a nurse should possess and what was important to them when or if they were being looked after by a nurse. I had collated all the comments from the Post-it notes and had grouped the comments on the notes by identifying key areas (Table 4.1), which the young participants later chose to call 'qualities', which respected their views and preferences.

Table 4.1:   Post-it note exercise

Young people's words (as per the Post-it notes)	Key areas (qualities)
• Nurses actually listening to you…they didn't believe how much pain I was actually in • Listen to the patient and not ignore them • Listen to you • Needing to be understood and listened to • Being listened to	**Being listened to**
• Good communication skills • Good communication skills • Good communication skills • Communication skills • Good interpersonal skills	**Good communication skills**
• Speaking to my parent instead of me • Talking to my parents instead of me about my condition and when explaining to speak directly to you and not your parent • I've been in a situation where the doctor/nurse talks to my mum rather than me (I'm 18) and then talks to me like I'm stupid (they're patronising)	**Talking directly to the patient (young person)**
• Positive attitude • Being positive	**Having a positive attitude**
• Caring to service users • Help you as soon as you need it	**Caring**
• Patient confidentiality • Not having much privacy considering my age	**Maintaining privacy and confidentiality**

• Telling me I'm going to do something instead of asking	**Asking for consent**
• Letting me know what's going on	**Being informed**
• Reassurance • Even when if what's happening is negative – assuring you that they will help	**Providing reassurance**
• Not rushed • Takes lots of time to get seen to – after asking	**Taking time**
• Nurses need to be patient	**Being patient**

To ensure that their participation was consistent (Aked & Stephens, 2009; Hart, 1992), the young participants were asked whether they felt this represented what they had initially written on the Post-it notes. They confirmed that this was a true representation of their views; however, they thought that 'respect' should be considered. We agreed that this could be included in the 'maintaining privacy and confidentiality' area. In turn, I wanted to ascertain what the young participants thought we should label these 'key areas' as, and they suggested that the term 'qualities' should be used.

4.3.2 Diamond ranking of the qualities (Day 2)

The young participants were asked to work in small groups (threes or fours) and to use diamond ranking to prioritise the qualities. Diamond ranking is a recognised thinking tool activity that can be used with a group of people to generate discussion around a particular topic (Rockett & Percival, 2002). In their practical guide Shepherd and Treseder (2002) discuss how to engage children and young people in consultations, and one of the activities that are suggested is 'diamond ranking', which I felt was beneficial for this study. The task of diamond ranking is to prioritise a list of statements, words or pictures according to a descriptor in the shape of a diamond. For example, the descriptor could be the level of importance, interest or

significance (Clark, 2012). For this exercise, the young participants were required to rank the qualities in order of importance for them.

The young participants were provided with an example of how to use diamond ranking and were then asked to complete this exercise using the qualities generated from the 'Post-it' exercise. For this, the young participants were seated around a table with a facilitator (lecturers and college tutor) with each group.

The groups were asked to discuss each quality in turn and negotiate with each other how the qualities should be ranked. This discussion could be based on personal experiences or on what they perceived to be important. From what I observed, the groups appeared to do this well and the young participants were able to provide a rationale to their peers about why one quality should be placed as a higher priority than another. This exercise enabled the young participants to express their opinions within a small group, and they all appeared to contribute. Fallon et al. (2008) also reported that diamond ranking enabled the participants to state their views freely whilst still achieving the objectives of their project. This activity meant the young participants could be open and challenging with each other. Once all the groups had ranked their qualities, they were asked to join as a whole group to re-rank them collectively. This proved more difficult than the first exercise, as there was such diversity amongst the three groups' rankings; they commented that they felt this was a difficult task as they were all important qualities. Photo 1 provides an example of diamond ranking of the qualities. It was evident that there were some contrasting opinions amongst the groups. For instance, one group considered 'talking directly to the patient' as the highest priority, whereas another group ranked that as their lowest priority. However, there was a consensus amongst all three groups that 'being listened to' was a high priority.

In order to facilitate this exercise, I asked the young participants whether they felt that a different shape would be easier or more appropriate to use. The discussion developed into shapes with nine sides, and during this a young participant identified a shape on the computer podium that had nine sides; it was an equilateral 't-shirt' shape. Initially, the young participant thought this was humorous, but the group all agreed that this shape could be used, and the qualities were arranged around this (see Photo 2). They stated that collectively the qualities represented being

'professional', and they agreed that all the qualities were of equal importance and value.

Photo 1: Diamond ranking of qualities
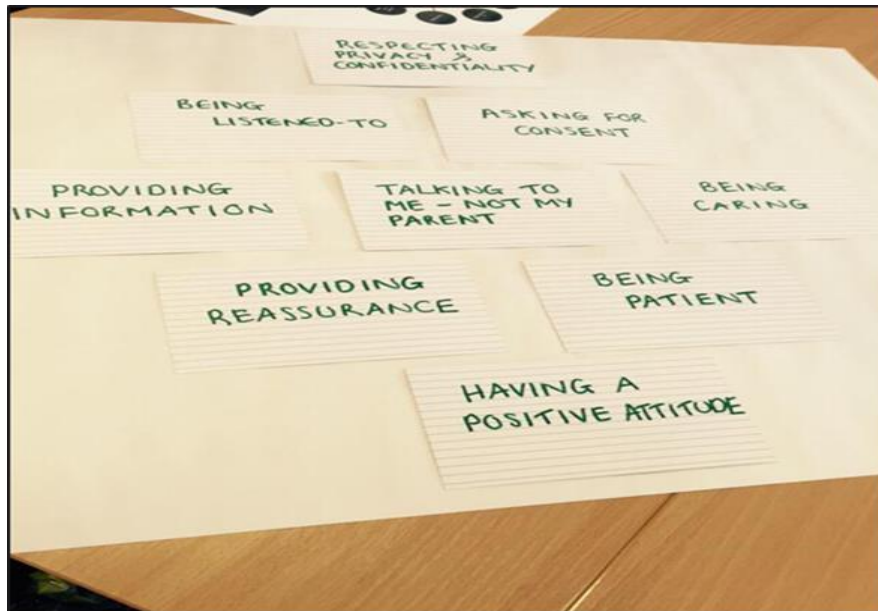
Photo 2:   Equal qualities
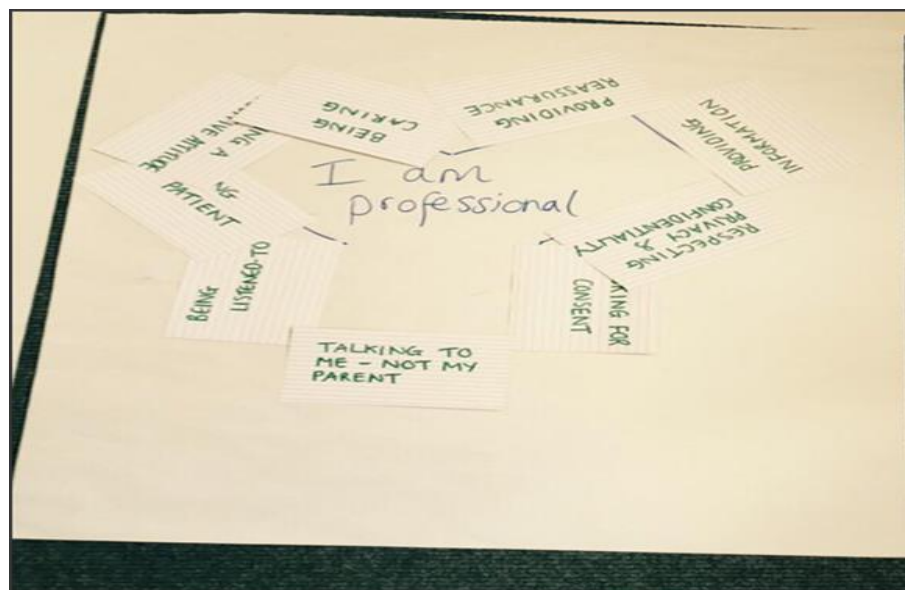
4.3.3 Observation of student nurses participating in a simulation session (Day 2)

In the afternoon the young participants observed three student nurses undertaking an HFS session concerning a child (manikin) who was being admitted to hospital for an appendicectomy. There were several roles within the scenario: SimJunior® was used to represent the child, a CYP lecturer acted as the mother, and a CYP lecturer acted as the mentor/facilitator. Three third-year CYP student nurses participated in the scenario. The HFS session was streamed into a separate room where the young participants were observing with me. Whilst the session was running, the young participants were asked to consider the nine qualities from the diamond ranking exercise in relation to the interactions that they were observing between the student nurses and the child. I gave them some paper to write some notes on. Once the session had concluded, I discussed each of the nine qualities with the young participants and asked them to tell me about their observations of the student nurses in relation to the nine qualities. One of my supervisors was present and took notes on what was being discussed during this part of the session.

However, during this exercise I noticed that some of the young participants were not contributing, but by this I mean they were still engaged. Keeping young people interested in research and motivated can at times be a challenge (Schafer & Yarwood, 2008). Therefore, an activity was introduced that meant that all individuals participated, which consisted of passing a ball from one person to another. It was important that all the young participants were able to express their views during this exercise and that the discussion was not limited to the most vocal participants. Some of the young participants stated that they felt anxious speaking in front of the whole group and found the work in the smaller group less intimidating. Geldard and Geldard (2001) suggest that children and young people may feel uncomfortable speaking openly about personal issues or experiences in a group setting. Hughes and Quinn (2013) suggest that a facilitator must recognise that individuals in a group will participate differently. This may be due to feelings of inadequacy, a lack of self-esteem, a lack of knowledge, poor preparation or personality factors (Hughes & Quinn, 2013). Therefore, for the future training sessions, work in small groups was used as this was considered the most supportive and effective way to explore the young participants' views. However, it is acknowledged that this can be resource-

intensive as more than one facilitator is required and duplication of materials may be necessary. Geldard and Geldard (2001) identify that larger groups are more economical, but ideas can be diluted and cohesion may be compromised. Therefore, it is important that a balance between the two is achieved, which is reported in this study.

4.4　Discussion relating to the qualities

Respecting privacy and confidentiality was discussed in the context of discussions being overheard, in particular, from bed to bed and at the nurses' station. Certain questions (for example, having bowels opened) were considered by some as embarrassing, and the nurse should respect the child or young person when asking such questions. In the session the young participants noted that the student nurses were speaking quietly and were 'polite' when asking personal questions. Robinson (2010) conducted a review of the literature relating to the views of children and young people regarding healthcare professionals. She analysed 31 research studies and found that children and young people considered privacy and confidentiality as an essential component of the role of the healthcare professional. Fallon et al. (2008) also found that respecting privacy was important to young people who were diagnosed with cancer.

It was suggested by the young participants that if a nurse has a positive attitude they would be more likely to engage with the nurse and confide in them. More specifically, a 'gloomy' attitude of the nurse could negatively affect the mood of the child or young person. In the session the young participants stated that the student nurses answered questions positively and continued to reassure the child and mother. The positive attitude of the student nurses was reassuring and appeared to put the child and mother at ease. Randall and Hill (2012) found that children and young people want the nurse to 'make the bad stuff seem better', thus depicting a positive and reassuring attitude.

Being patient was identified as a key area. The young participants suggested that it was important that nurses did not rush or get frustrated when something needed explaining. Brady (2009) conducted a qualitative study to determine the characteristics of a good nurse from the views of children in hospital. The findings suggested that children valued nurses who would deal promptly and swiftly with a

task that could evoke fear in a child. In turn, another child in Brady's study stated that patience and politeness were essential characteristics of a nurse. Randall, Brook and Stammers (2008) found that children and young people thought that student nurses should be taught not to rush care, take their time and engage in a 'non-medical' chat. From the simulation sessions it was recognised that the student nurses demonstrated patience throughout the care delivery. For example, when taking the blood pressure of the child the student nurses did not get frustrated when the child was asking questions and remained friendly with a positive tone of voice. Brady (2009) recognised that children were sensitive to the body language and tone of voice of the nurse. Being friendly and approachable is discussed in much of the literature as being a fundamental trait of a nurse (Brady, 2009; Fallon et al., 2008; Fletcher et al., 2010; Randall et al., 2008; Randall & Hill, 2012; Robinson, 2010).

Although the qualities were distinct they were not necessarily discrete. This became evident when the young participants noted behaviours that could be assigned to a number of different qualities. For example, 'being patient' and 'being caring' both included being friendly, having a 'chat', giving patients time, being approachable and smiling. Facial expressions and body language were also noted as being important when expressing a caring nature and patience. In the HFS sessions the young participants felt that the student nurses exhibited a caring nature. This was demonstrated by being approachable, asking the child about likes and dislikes, asking the child 'Are you OK?' and getting the medication quickly and on time.

Talking to the child/young person directly rather than the parent was identified by many of the young participants in the 'Post-it' exercise. Some gave specific examples of visiting the GP and stated that their mother had added to their symptoms. However, when a child is less than 16 years old one young participant acknowledged that at times parental input is necessary. For example, in relation to the contraceptive pill there could be a safeguarding issue, and parents may, at times, need to be involved. Others have reported the benefit of using parents to scaffold children's communicative competence (Livesley & Long, 2013). In the simulation sessions the young participants noted that there was a continued effort by the student nurses to involve the child in the care provided and consider the child's perspective. In turn, they spoke directly to the child and introduced themselves to the child first rather than the mother. Randall et al. (2008, p. 24) found that children appreciated nurses

who 'didn't look down on you', whereas Fallon et al. (2008) established that one young person asked not to be treated like a child. Involving children and young people in decision-making is essential, and, although 'decision-making' was not specifically referred to by the young participants, they did discuss and write down that it was important that they are listened to and emphasise that a nurse should be talking directly to the patient.

Some of the young participants recognised that the provision of accurate information by a nurse was necessary. In turn, this should be delivered without the use of technical language, abbreviations or jargon. In the simulation sessions there were a few occasions when technical language was used, for example, 'cannula' and 'bowels'. In the Post-it exercise one young participant identified that the nurse should clarify that the information provided has been understood before leaving the room. In the simulation sessions explanations were given by the student nurses regarding the reason for the child being nil by mouth and the medication administered. In order to provide accurate information, a nurse must be knowledgeable. Fletcher et al. (2010) determined that children and young people want nurses to be 'experts', whereas Robinson (2011) found that providing accessible information and being informed were important factors.

Listening to children and young people was recognised as an intrinsic component of the role of a nurse. One young person stated that it was necessary not to be ignored, and another said that often they thought that the nurses felt that young people (because of their age) did not know what they were talking about. Randall et al. (2008) ascertained that a good nurse is someone who is happy to listen and doesn't turn their nose up at the child.

In the simulation sessions it was observed that the student nurses were involving the child in their conversations and were listening to the child when asking about pain, for instance. Fallon et al. (2008) confirms that it is critical that nurses are good listeners and that they are not patronising when talking to children and young people. In turn, verifying understanding is also essential. The young participants identified that the student nurses recapped on previous conversations to confirm that the child had understood the information provided.

The ability to provide reassurance was an area that was discussed consistently amongst the young participants. More specifically, they suggested that the nurse should display empathy and honesty, break bad news gently and be supportive. Randall and Hill (2008) found that children and young people stressed the need for nurses to be trustworthy. In the simulation sessions the young participants recognised that the student nurses provided reassurance continuously and were able to state some examples. They noted that the student nurses told the child that the observations were satisfactory, that they would get better over a period of time, medication would make them better and the Ametop® would help with the pain when having the cannula inserted. The young participants also observed that the mother was being reassured by the student nurses, in particular, in relation to her anxiety about not bringing her child to hospital sooner. The young participants discussed that nurses need to ask for consent before carrying out a procedure or intervention and stated that often they are already performing the procedure (taking blood pressure, for example) whilst they are asking if it is OK to do it. Moreover, they identified that, depending on the age of the child, consent should be gained from the child/young person and not from the mother. Randall et al. (2008, p. 24) interviewed one child who stated that nurses "should speak to you nicely and explain what they are going to do, and why". Similarly, the research by Fletcher et al. (2010) determined that children wanted nurses to explain what was happening to them. This was evident in the scenario, and the young participants recognised that the student nurses asked the child if it was okay to take their blood pressure and explained what would occur during this procedure (for example, tightening of the cuff).

The day concluded after we had discussed all the qualities in relation to the HFS sessions that the young participants had observed (Table 4.2).

Table 4.2:   Application of the qualities to an HFS session

Quality	Diamond ranking exercise	Applying the quality to an HFS session
Respecting privacy and confidentiality	-Need to know some things about you but not everything -Not had experience of breaching confidentiality	*Speaking quietly around patient *Being polite about asking personal questions, for

	-Should respect patient, can get embarrassed (washing etc.) -People who were worse off got treated better -Handover at the nurses' station – everyone can overhear (incontinent etc.)	example, regarding bowels
Being patient	-Not rushing -Not being frustrated when you don't understand -Anxiety problems, speech impairment -Encourage independence (not getting frustrated) -Young people may have trouble talking about issues -Older people need to be more patient	*Saying the same but in different words *Buying time *When doing blood pressure nurse didn't get frustrated *Friendly *Tone of voice *Remained positive *Asking constantly 'can I go home?' Waiting for the surgical team *Questioning *Not saying 'I just told you that'
Talking to me and not my parent	-Going to the GP with parents -Parents may miss things -Mum added to the symptoms -Feel nervous going to doctors or booking appointment on the phone -Important for safeguarding issues -Addressing you – do it more when you're over 16 -Long-term illness, continually talk to the young person -Provide them with information about 'transition to adult services	*Getting the child's perspective *Important to know the diagnosis *Introduced themselves first to the child *How are you *Pain scale/assessment – asked the child

Providing information	-Being able to speak in fluent English -Being informed -Not using technical language, jargon, abbreviations, provide in lay terms – can cause concern if not understood -Clarifying that patient understands before leaving the room	*Explaining about medicines and being nil by mouth *Using 'lay' terms/ordinary words/not using medical terms (cannula, bowels) *Alleviating worry/anxiety *Accurate information *Explaining about the Ametop®
Being listened to	-If didn't listen wouldn't know what was wrong -If worried which can be worse – sometimes disregard this -Not being ignored -Young people take you seriously if you're listened to -Think if you're younger, not experienced, don't know what you're talking about	*Still need to listen to the parent *Explaining to the child 'why' *Bringing the child into the conversation *Recapping on previous conversation *Pain scale
Providing reassurance	-Shows empathy -Tell the truth, be honest -Break bad news gently -Use a quiet environment, privacy (RESPECT) -Supportive -This links to providing information	*Will get better but over a period of time *Saying the observations were OK *Can go home but not yet *Reassuring mum as she felt guilty for not bringing him *Xbox, distraction, finding him something to do *Medication – will make you feel better *Ametop – won't hurt for you to have the cannula *Blood pressure – good for his age

Being caring	-Showing empathy, putting self in the position that the young person is in	*Approachable
		*Reassurance
	-Talking about how you (young person) feel about things	*Letting mum be present
	-Can only empathise to a certain extent	*Asking 'are you OK?'
		*Pain scale
	-Having a chat	*Asking about likes and dislikes, being friendly
	-Giving 'brews'	
	-Smile	*Getting medication quickly and on time
	-Approachable	
	-Facial expressions	
	-Respecting privacy	
	-Giving people time	
Asking for consent	-Mental capacity	*Blood pressure – asking if it's OK to do something
	-Asking once they are doing the procedure (blood pressure, for example)	*Talking through the procedure
	-Not asking mum	*Medicines – asking for name and date of birth
	-Links to confidentiality	
	-Could make you feel uncomfortable and insecure	*Can I touch your arm for the pulse
	-If a student – would depend on the procedure	*Asking how he was feeling
		*Asked about allergies
Having a positive attitude	-Positive attitude reflects on the person	*Should mum have brought him in earlier?
	-Not bringing personal life into work	*Reassuring – keeping mum positive
	-More likely to engage if the nurse is positive	*Speaking directly to the child
	-Could upset patient more if the nurse is 'gloomy'	*Nurse answering questions positively
	-More willing to say what is wrong with you	*Talking generally about the Xbox

4.5 Preparation programme (Day 3)

Days 3 and 4 were scheduled for the week when the young participants returned to college after their summer break and were consecutive days. I was relieved that all the young participants had returned following such a long interval between the previous and current sessions. To concur with Schafer and Yarwood (2008), the motivation of the young participants perhaps stemmed from their curiosity, interest in the research project and vocational aspirations.

4.5.1 Finalising the feedback tool (Day 3)

First, I asked and confirmed with the young participants if they were still happy to continue and participate in the study. This was particularly important as there had been a long break since I had last engaged with them and they all stated that they still wanted to be involved. We did some introductions again and revisited what we had achieved in the previous two days. The first part of the day was dedicated to finalising the feedback tool. I asked the young participants to revisit the qualities from the previous session and it was agreed that they would work in small groups to narrow these down into three larger headings or categories in order to make the feedback tool easy to use. This proved to be quite a difficult task, as all three groups came up with different thoughts regarding this. However, I was keen to facilitate the group discussion and encouraged the young participants to negotiate what the final tool should look like. After discussion, they agreed on the three headings communication, respect and attitude, as they felt that these more generic headings represented all the qualities. **Communication** included being patient, being listened to and being caring. **Respect** included providing privacy and confidentiality, providing information and asking for consent. **Attitude** included having a positive attitude, talking directly to the patient and providing reassurance. These were presented on an A4 piece of paper with space for the young participants to write comments in whilst they were observing the student nurses (see Appendix 9). They would then use their notes to provide feedback to the student nurses in the

debriefings. On Day 4, I would provide some guidance on how to use the feedback tool in more depth and the principles of providing feedback.

4.5.2 Writing the simulation scenario (Day 3)

The next part of Day 3 was dedicated to writing the simulation scenario that would be facilitated for the student nurses. To start, I provided the young participants with a brief outline of the clinical aspects of the scenario. I needed to ensure that it was relevant for the student nurses, aligned with module outcomes and appropriate for their stage of training. The brief outline was:

'[Name] has presented to the children's emergency department with an exacerbation of asthma and is accompanied by her father'.

The young participants were then invited to ask me anything that they needed clarifying, for instance, what 'exacerbation' means. Prior to Day 3, Diane had asked the young participants to read and find out about asthma in young people. Some of the young participants seemed to have a good level of knowledge regarding this; for some, this had been gained through their own personal experiences of having asthma. I asked the young participants if they could think about the background and context of the scenario. To do this, I discussed using the Dimensions of Health model (Naidoo & Wills, 2016) and a body map. As the young participants were enrolled on a health and social care course, they were familiar with both models. All but two of the young participants chose to use the body map: see Appendix 10 for an example of how one young participant used the body map. Once the young participants had completed this exercise, I asked them to discuss their ideas in small groups. Following this, we discussed the groups' ideas as a whole, and the whole group started to agree on some of the demographic details of the person in the scenario. These details included her name (Elizabeth), family (mum [Lisa], dad [Pete] and brothers [John and Michael] aged 7 and 10) and hobbies (trampolining, Morris dancing, swimming and going out with friends). Hearing the ideas from the young participants was extremely pleasing, and they all appeared to contribute to this part of writing the scenario. I took some notes during this session and explained that we would finish writing the scenario when the young participants returned the following day.

4.6   Preparation programme (Day 4)

This was the final day of preparing and working with the young participants before they observed the student nurses undertaking the HFS session with the scenario that they had designed. On Day 4, the scenario was finalised, a practice run of the scenario was demonstrated and a discussion about using the feedback tool and the provision of feedback was provided. The first exercise of the day was to complete writing the simulation scenario according to their body maps and initial thoughts from Day 3.

4.6.1   Finalising the scenario (Day 4)

On Day 3, the young participants had already established most of the social background of the scenario. On Day 4, the young participants added more detail and finalised the scenario. I wanted to ensure that the scenario remained true to the perspectives of the young participants; therefore, I used a PC and a projector to write down their ideas as they contributed (see Appendix 11 for the final scenario). Once this had been agreed, we then had a run-through of the HFS session using the scenario that the young participants had designed.

4.6.2   Practice run-through of the simulation session (Day 4)

It was important that the young participants were familiar with the scenario that they had designed and, as with all simulation sessions, a run-through was scheduled. I played the role of the student nurse whilst the young participants observed. Three of the young participants had volunteered to provide the voice of the manikin and were invited to be in the control room with the simulation technician. The simulation technician provided the voice of the manikin so that the young participants who had volunteered to provide the voice could observe how this would be carried out. The rest of the young participants observed the run-through from another classroom. They were given copies of the feedback tool that they had designed and were asked to make notes about what they observed. This enabled them to become more familiar with the tool and prepared them for delivering feedback to the student nurses. Following the run-through, I asked the young participants to give feedback on my performance using their notes. I explained that they would be delivering similar

feedback to the student nurses and the lecturer would be providing feedback on the technical and clinical skills of the student nurses.

4.6.3 Using the feedback tool in the debriefings (Day 4)

As part of the training programme of the young participants it was essential that they received sufficient preparation regarding the delivery of feedback. Two hours were dedicated to this, and I gave an overview of what feedback is, the benefits/constraints of feedback, providing feedback using a 'feedforward' approach and feedback in debriefing. Although predominantly the 'feeding forward' method refers to feedback for written assessments, this framework can also be adopted for the use in practice-based assessments. This framework for delivering feedback has many similarities with the theoretical concept of reflection-on-action and models of reflection (Driscoll, 2000; Gibbs, 1988; Johns, 1995; Kolb, 1984). Notably Driscoll's model of structured refection (Driscoll, 2000) focuses on three stages posing the questions: 'What' 'So what' and 'Now what', which are comparable to the three stages in the 'feed-forward' framework and are applicable to feedback following a simulated scenario. In simulation-based education the facilitator must always involve the learners in a debriefing following participation in a simulated scenario. The debriefing stage is usually guided by an adapted model of reflection and is one which suits the learners and the instructors needs. In this study feedback was referred to in the context of the HFS sessions and the role that the young participants had in delivering feedback to the student nurses in the debriefings.

I was aware that the young participants did not have any experience of delivering feedback in an educational setting. In this study it was important that I reassured the young participants that they would discuss their feedback with the lecturer before providing it to the student nurses. In this way, the lecturer would be able to support the young participants in delivering the feedback and also in the way that it was delivered. For me, it was important that the young participants felt supported by me and the facilitators of the HFS sessions whilst they were observing and giving feedback to the student nurses. The Quality Assurance Agency for Higher Education (2015) suggest that a safe environment for feedback is paramount and all feedback (including negative feedback) should be discussed. Therefore, in a group setting ground rules should be agreed prior to the feedback session and should incorporate

aspects such as confidentiality, speaking one at a time, listening to others, respecting each other and being sensitive and supportive. It was important that the young participants devised some ground rules, which they did before the simulation day.

For many years debriefing has been used in healthcare practice as a retrospective method of reviewing and analysing critical incidents. Over the last decade there has been a considerable increase in the amount of literature relating to debriefing in simulation-based education (Arafeh et al, 2010; Cant & Cooper, 2011; Dreifuerst, 2009; Fanning & Gaba, 2007; Levett-Jones & Lapkin, 2014; Wickers, 2010). Fanning and Gaba (2007) recognise that debriefing enhances learning opportunities and enables learners to develop from their mistakes. Flanagan (2008, p. 155) describes debriefing as:

> "*The purposeful, structured period of reflection, discussion and feedback undertaken by learners and teachers immediately after a scenario-based simulation exercise*".

Here, it is noted that feedback constitutes a part, but not all, of the debriefing process. The debriefing should be facilitated by the lecturer or practitioner but led by the learner. The role of the young participants was to provide feedback to the student nurses using the feedback tool, and they were asked to specifically refer to the headings (communication, respect and attitude). In the debriefing, the facilitator of the HFS sessions provided feedback on technical skills, application of knowledge and clinical decision-making. Hesketh and Laidlow (2002) suggest that service users are unable to comment on technical skills but can provide valuable feedback on attitude and communication. The aim of this was to ensure that the perspectives and thoughts of the young participants were listened to by the student nurses so that they could develop their skills further.

4.7 Summary of chapter

The preparation work with the young participants occurred over a period of six months. Although some of the young participants had been withdrawn from the study on the first day by the curriculum leader, I was content that 11 of the young participants had attended the training days. I worked with the young participants to

co-design the simulation scenario and feedback tool over four days. Through these exercises I had involved the young participants from the planning stage of the simulation through to the debriefings. The young participants were actively involved and were able to have their voices listened to throughout the process.

Chapter 5

Findings (1)   Meaningful involvement

5.1   Introduction

Here, the first of the three concepts (meaningful involvement) is presented. It provides the grounding of the two further concepts (creating a more authentic reality and uncertainty) presented in Chapters 6 and 7. The structure of this chapter follows the sequential timeline of the workshop sessions and HFS sessions. First, I consider the young participants' initial work in which the scenario was developed for the HFS sessions before considering their work on the feedback tool; this approach was fundamental in privileging the position of the young participants in this study and shedding light on the actions that adults may use to transform the place of young people with whom they work.

Presenting the findings for this concept using the timeline was important, as it helped to show the importance of the working relationships between the young participants and their relationship with me. In turn, this enabled me to delineate and interpret the structural challenges inherent in the relationships between the young participants and the student nurses more clearly. Key concepts from the new sociology of childhood, notably, 'being a child' and 'children as social actors' (or 'agency'), were instrumental in further developing my interpretive insights to produce a synthesis across all data sets. This led me to identify the themes of *finding voice, developing voice, sharing voice, challenging voice and personal development*. There was also evidence, grounded in the data, of transformative actions that adults took to enable and scaffold the independent actions and decision-making of the young people, such that they grew in confidence and competence. I then consider the impact this had on the young people, the development of their insight into 'self' and the benefits that followed for the student nurse participants. I contend that the young participants were able to express agency through their involvement in the simulation workshops and simulation sessions and that the overall experience contributed positively to their resilience.

5.2 Finding voice

The Naidoo and Wills (2009)[9] Dimensions of Health model provided the basis for an introductory session to this model. As discussed in Chapter 4, section 4.4, this was chosen as it is a widely used model that identifies all aspects of a person's health and enables a holistic consideration of a person. My intention was that the young participants would use this to help them consider what information they wanted to include in the scenario in terms of background information, such as cultural context and social and familial history. In addition, a body map provided a useful tool for them to make notes or illustrations. They were freely able to choose which of the tools to use or could have chosen to use both if they wished. Three of the young participants reflected on this part of the introductory session during the focus group interview:

> "…*The piece of paper that you gave us with the body on it…I thought that was really good. And the PowerPoint* [Naidoo and Wills] *you did, it gave us hints…it helped us what to put, but it was all of our own ideas…*" (Lexy)

> "…*I liked the body map, I thought that was quite good. Dimensions of Health, I used some of it, but I applied it more to the body map than using the actual sheet…*" (Jenny)

> "…*It was like our ideas…that made the character in the scenario as well. So that we got a part, we made the person as well so that helped, it gave us involvement shall we say…you took the ideas on and they took your ideas into account…*" (Chelsea)

Choice of activity and respect for independent expression are important aspects of work with young participants. However, the young participants were able to reiterate how the tools were instrumental in helping them to construct the scenario and the specific characteristics of their scenario character (Elizabeth). Here, the approach had worked, and I had been successful in facilitating the young participants' involvement. It was clear that they felt ownership of their ideas. Knowing that their

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[9] The Naidoo and Wills (2009) Dimensions of Health model includes physical, mental, emotional, spiritual, sexual and social health.

ideas were valued and respected in this early activity was key in my ongoing and developing relationship with them.

They went on to tell me how they felt about writing the simulation scenario:

"*We all…discussed what we wanted, and it all got listened to*" (Amelia)

"*I liked how we still had a big input in it as well because it was our scenario*" (Gina)

"*You edged us in the right way, but you didn't tell us what to do*" (Gina)

"*It gave us a lot of independence*" (Sarah)

Here, they acknowledged their collective input and that all members of the group had participated. Independence to write what they wanted signalled my intention to respect their agency, in other words, their capacity to think and act independently. However, scaffolding their efforts by providing useful tools was also important. As Newman (2004) notes, it is important that young people have a mentor from outside the family for support whilst having the opportunity to be involved in activities that will have a positive effect on others. Daniel and Wassell (2002a, 2002b, 2002c) add that having this level of independence and involvement in decision-making assists in building self-esteem and resilience, both important factors in improving confidence and competence.

It was also important that I was able to scaffold rather than lead the contextual information in the scenario. That I was 'not telling them what to do' was paramount. As noted by one young participant:

"*…it was our opinion for our values and our aims…*" *(Jenny)*

Another noted that:

"*…you were referring back to us because we are the young people and we have more of an idea of what it's like now, so you gave us more independence*" (Sarah)

Here, Sarah revealed her understanding that, as a young person, she had a claim to a more appropriate emic[10] position; in other words, that her subjective, interpreted

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[10] In this study 'emic' means being within a particular social group

perspective was a better fit for what would inform the development of the character and personality of the young person in the scenario than anything I or my colleagues could provide. Although I have been a young person, I acknowledge the greater expertise the young participants brought regarding contemporary life experiences of other young people. Prior to undertaking this study, I was familiar with the practice of lecturers developing scenarios based on their professional knowledge and expertise as children's nurses and educators. This represents a more distant position than the emic perspective brought by the young participants. With hindsight, I was working in accordance with commentators such as James and Prout (1997) and Mayall (2002), that is the young participants had perceived that I had privileged their perspectives. Looking back, I now realise how important it was that I did not lead the writing of the scenario. I resisted the temptation to use my position as an adult, researcher and simulation expert to interfere with the young participants' agency in writing this. I wanted to embrace rather than constrain the disruptive force the young participants could bring to this work. In turn, the young participants reported their experience of being listened to and respected. James and Prout's (1997) explanation of the difference between being and becoming is useful here. As they note, young people are often constructed as less equal and less important than adults while they are in transition to becoming adult. However, I had respected their agency and their 'being' young people. As noted in the following excerpt:

> "*We also knew what we'd written down for the ideas of the person, so how we took them into account. So if you'd…made that person…we would have struggled to put them ideas into perspective…whereas we made the ideas*" (Chelsea)

Had I simply presented them with a pre-written scenario they might have struggled to contextualise and make sense of the session. They had ownership of the construction of the character in the scenario. In other words, having developed the character for the scenario meant they found it easier to relate to this than they might had a lecturer written it. I had never considered this important aspect of young participants' contribution in simulation and their involvement being meaningful.

However, I also became aware of the young participants' reflections on their respect for each other's ideas, both within and between groups. As one young participant noted:

> "…It was…our ideas that made that person [scenario character], each group put so many ideas down and then all the ideas got put together…it was kind of our person…" (Chelsea)

> "It was all kind of equal…obviously some ideas were more than others, but there was more of an equal of each group's ideas that went into it really" (Chelsea)

In this way, I had further scaffolded their efforts and had resisted the temptation to act as a more knowledgeable adult. The young participants had worked as a group and had acknowledged that each other's ideas had been represented. Group work in primary, secondary and tertiary education is an established teaching and learning strategy. Quinn and Hughes (2013) assert that group work facilitates the discussion of values and feelings and creates less of a barrier between teachers and learners. However, they do not comment on reducing barriers between group members. I had expected, reasonably, that the young people would be used to group work. They were all following the same further education programme of study. However, my perceptions of the young participants as a cohesive, pre-existing college group were incorrect. I learned that they came from disparate and diverse groups within the college with no established relationships. For now, although I cannot be certain, I contend that their feeling respected and being listened to helped them to respect and listen to each other. This is an important part of working with young people.

Other benefits were also evident. According to Grotberg (1995), adults can promote resilience in young people through problem-solving, communication and helping them to manage thoughts and behaviours. The results presented here suggest that this was happening. The activities in which the young participants had participated had required them to work and collaborate with each other and negotiate and challenge others' ideas. They appeared proud of their work and their ability to work cooperatively. For me, their emic perspective on being a young person added veracity and authenticity to the scenario. This argument is subjected to further critical discussion in Chapter 6.

To summarise, it appears that the young participants were able to *find voice* through their involvement in writing the simulation scenario. In turn, it seems that being involved in the initial preparatory stages of the HFS session ensured that their contribution was valued not only by me but also by themselves. I had never considered this aspect of young participants' contributions but now understand this to be a notable factor in building resilience in young people (Grotberg, 1995).

5.3   Developing voice

Having completed the work on the scenario – the characterisation and social and family context – the young participants moved on to the development of the feedback tool. I had explained to the young participants that as part of the debriefings I wanted them to give feedback on their observations of the student nurses' using the observation tool that they had developed. As noted in Chapter 4, feedback consists of information that is conveyed to learners with the aim of being able to modify their behaviour or thinking in order to make improvements. I wanted the young participants to feel able to do this independently. Again, they told me about the importance of helping them, not by telling them what to do, but rather that they were able to make sense of the tool because they had developed it:

> "*It was good…we had the sheet* [the feedback tool], *because you wrote the three main headings and then.in brackets the bits of what we've mentioned the other week when we went. So that…helped a bit. Because we knew which section to put each feedback in*" (Sarah)

> "*It made it easier to understand…if we hadn't stayed that long on it* [developing the feedback tool] …*we might've struggled a bit more* [to give feedback] *but, because we spent so much time doing the qualities, it made the whole process* [of giving feedback] *a lot easier*" (Chelsea)

> "*Knowing the qualities and knowing what they had to do to fulfil the qualities was easier to feedback on as well. So, you could feedback through the qualities…it was so much easier to observe them because knowing what we'd done and what…how we created the scenario was all there…So, it was all in our minds of how to observe them and what to say and what not to say*" (Chelsea)

Here, Sarah and Chelsea discussed the importance of taking their time to develop the feedback tool. It seems that this had subsequently assisted with their observations and feedback to the student nurses. At the time, I was concerned that the young participants perhaps needed more time to create the feedback tool; however, from their accounts this was not the case. For them, they had ownership of the feedback tool and the qualities that they had devised. For me, this was an unexpected positive outcome for the young people that went beyond the production of a feedback tool.

The young participants went on to tell me about the development of the feedback tool and how they had used it during their observations of the student nurses:

> "*I think it was easy enough because obviously we had our big heading and then we had our branches that were coming off it…we could feedback on there what we thought they were doing and if they needed to do anything differently…*" (Louise)

> "*I think doing it as a tally, that was one of the other options, I think that would be a bit difficult to feedback on because we'd be restricted to things we could say, things from the start, if we'd missed it, we wouldn't know what they actually did right*" (Louise)

> "*Yeah, it was also even if you didn't know what to put under each heading…you could split them all and it wasn't restricting you. What you thought was supposed to go in which heading*" (Jenny)

The young participants had discussed in their groups several ideas about how to design the feedback tool. They had all negotiated and worked together to produce the final design. The young participants said that the three main headings (communication, respect and attitude) that they had devised on the feedback sheet helped them to collect and collate their thoughts, as opposed to a tick list of attributes, which they felt would have restricted them. When undertaking the group work, I had observed the young people discussing what they should write. During this exercise I took some notes, noting in my observations that they were working well together. It was clear that they were working cooperatively to develop and agree their ideas. They worked in a similar way to when they developed the simulation

scenario. They relished the freedom to design the feedback tool in the way they wanted it, once more being able to express their agency. They identified how working together had benefited them:

> "*I think it's made us all stronger as a group. We've all had to work together in different aspects of it, but then working together we've been able to allocate roles and things like that so we've all had our fair share in it all. I think it's built up teamwork and things like that*" (Louise)

> "*So when we were making up those groups, and then when I came up with the shape…I'll never forget that shape, and then when we was putting in all the different categories and then putting categories in them, expanding, and a lot more work and ideas and putting them all together*" (Sarah)

They had also chosen to have 'free text' boxes. It was encouraging that the young participants had found their tool easy to use; they felt confident with writing comments in the boxes. In Bandura's social cognitive theory, confidence is closely related to 'self-efficacy' (Bandura, 1997). However, he asserts that the word 'confidence' is nondescript and refers only to a strength of belief, whereas self-efficacy relates to being able to influence life events and have control over the way these events are experienced (Bandura, 1994). For Bandura, self-efficacy comes from the experience of mastery or having success with a task. Therefore, it is reasonable to assume that their perceived success in the development and use of the feedback tool could have enhanced their self-efficacy.

However, the young participants were less sure about what would happen once they had written their feedback down, as noted by one of the lecturers:

> "*A few times where they would say something like, I don't know, am I allowed to write negative things…I don't think we'd realised you were going to give the student nurses the copies of the written comments…So once you'd said that, I think they were perhaps a little bit more guarded at what they wrote down, because they obviously realised then this person's going to actually see what I've* [the young person] *written*" (Danny)

I had not considered this, and it had potential consequences for the feedback they were prepared to share, and their feedback may have been contrived. That said, little is known about the tone and veracity of feedback offered by professional assessors, nor is there any evidence to suggest this may be more reliable or valid.

In summary, the young participants appeared to progress from finding to developing their voices through their involvement in the development of the scenario and feedback tool and this provided a meaningful experience for the young participants. They felt valued and listened to and were able to express their agency. The student nurses and lecturers also identified the significance of their involvement.

5.4   Sharing voice

The young participants' observation of the student nurses and their participation in the debriefings was the final stage of their involvement in the planning and facilitation of the simulation sessions. As discussed earlier, the young participants had designed a feedback tool to help guide their feedback to the student nurses (with support from an academic member of staff). Some of the student nurses described how they felt about receiving the feedback from the young participants:

> "*It was nice to hear it from them…you get it when you're in practice sometimes from your mentor and staff but…it was nice to hear it from like somebody who you may have to care for in practice, to see what they genuinely thought*" (Claire)

> "*Yes…the actual views of a service user*" (Sandra)

Claire and Sandra valued what they termed as "genuine feedback". They had valued the young participants' feedback, as they were closer to the children and young people with whom they worked in practice. This was a positive learning outcome for the student nurses. Specific emphasis was given to the value of receiving feedback from someone they might care for in clinical practice. The importance of this was not lost on the young participants:

> "*It was probably good for them to get feedback off someone different than just their tutors*" (Sarah).

It appeared that the significance of this rested on the student nurses' experiences of receiving feedback in practice from parents rather than children and young people:

> "*When you are in practice, the parents give you the compliments, it's not the actual patient, so it's nice for the patient to give you feedback*" (Belinda)

Here, Belinda expressed her gratitude regarding the feedback provided by the young participants. As discussed earlier in Chapter 2, parents are often the proxy voice of children and young people in receipt of healthcare. Lambert, Glacken and McCarron (2008) conducted an ethnographic study on the nature of communicating with children in hospital; they found that when communicating with hospitalised children, they are often positioned in the background and overshadowed by their parents and healthcare professionals. In this work, I contend that involving the young participants in the process of feedback enabled them to have a privileged position and, when expressing their views, they were not overshadowed by adult voices.

The student nurses also noted that the feedback from the young participants was different from that received from their mentors or tutors. Their comments emphasise the importance of feedback from the children and young people with whom they work. Hearing the views of those for whom they cared was not just self-satisfying, it helped to develop their confidence and insight, and this was not lost on the student nurses:

> "*…it was nice to hear their views…in placement you don't often hear the views of a patient, just feedback from your mentors. So it's nice just for them to say, 'Oh, I liked how you did this, I liked how you did that'…*" (Sajeeda)

Of note was how one student nurse participant had made the link between this and her performance in practice:

> "*…Oh, so maybe when I am on placement this is how my patient feels*" (Sajeeda)

Others concurred:

> "*I think, as a person, I am very unconfident in myself, so I don't think I am good at anything, and that's just me…You get feedback off your mentors quite*

a lot in placements…but for someone not 'nursey' to say, 'Oh I really liked the way you did this', it gives you that bit of a confidence boost" (Paula)

Sajeeda and Belinda acknowledged their understanding of the value and uniqueness of receiving feedback from the young participants. They also considered what this experience might mean for them in their future placements. They recognised that, as the feedback provided was from young people, it was more likely to have a positive impact on their practice. This was an unintended positive outcome and further benefit to their learning:

"*Yeah, because that's who you initially…who you want to be like pleasing*" (Julie)

"*It's nice to actually have someone look at you and not have competencies just to tick you off with…rather than just saying, well, your communication was actually really good and I liked the way you said this…whereas on placements it's a case of, well, you need to meet this and I don't think you've met that*" (Florence)

"*I think it's good to see a different perspective of it…you know you get all your mentors…it sounds really stupid but it's like a hierarchy. So you've got your mentors…who give you the advice, but it's nice to see somebody who's not a qualified nurse or not even a student nurse, yet to say stuff about you is nice. It's a different aspect*" (Belinda)

Belinda had acknowledged the notion of an assessment 'hierarchy' in practice placements. The mentor was at the pinnacle of this, with non-qualified members of staff or service users ranked lowest. It was in this context that feedback from the young people offered a different perspective from that of feedback from a mentor or peer. In spite of the established or official hierarchy, feedback from service users was valued most. That said, most often, all documentation of any assessment came from mentors. It was, it seemed, difficult to have feedback from children and their families documented in the same way:

"*We're not allowed to ask them…because you can't go up to a parent and say, 'can you fill this in?'…And then your mentor is that busy that you don't really like to ask*" (Mandy)

> "*You don't get comments on everything as a wide aspect, you just get the competencies that you need, so a lot of the time you don't get communication and stuff*" (Paula)

There is currently an opportunity in the practice assessment document for a service user or parent to write feedback. However, the students had come to understand that it was for the mentor to request any written feedback, and this meant that the appropriate sections in the practice assessment documentation were seldom completed. Another student participant commented on how she felt about this:

> "*There's been loads where…I wish I could just say it because I know they would do it, but I mean I've had such good feedback…On my next placement, though, I think I'm going to introduce it and just say I'm just letting you…there's this in my book…in case a parent says anything positive, if they wouldn't mind, would they be able to fill it in…just because I'd like to have it*" (Claire)

Claire's comments and those from other student participants had followed on from the discussion about receiving feedback from the young participants during feedback. They led to the expression of a strong desire to seek service user feedback in future practice placements. This points to the value that student nurses place on receiving alternative perspectives about their practice. One lecturer also made some comments in relation to this aspect:

> "*I think they* [student nurses] *could see the value in what the young people were saying. I think perhaps, possibly, to have more credibility coming from the young people than what it might have had from us as lecturers, as adults*" (Pat)

The lecturer participants concurred that the young people made a meaningful and valuable contribution to the debriefings, again confirming the importance of the young participants being able to express their views and agency. Pat stated that the feedback provided from the young participants would add credibility to the debriefings.

Another of the lecturers told me about the young participants' involvement in the debriefings:

> "*I wanted them to feel quite involved. So I tried to make sure that they were brought into it quite early on and encouraged them to speak and always gave them the opportunity to add any final comments as well at the end…we were just a little bit more conscious that these are young people that have come and we need to make sure their role was valued and they were quite central to the debrief*" *(*Danny)

Danny recognised the importance of supporting and involving the young participants in the debriefings. In this instance, there is evidence of an intention to facilitate the young participants' agency in order that they had and exercised their right to make a valuable contribution to the debriefings. Scaffolding young people's exercise of agency is recognised as a vital component in the development of resilience. The adult relinquishes some power and attempts to redress the more usual child/adult relationship by shifting from being an authoritative figure to being a role model and mentor to the young person (Daniel & Wassell, 2002; Grotberg, 1997; Newman, 2004). Key among evidence that this had taken place was that the young participants felt listened to during the whole process and that they were enabled to speak freely in the debriefings.

In addition, one of the lecturer participants alluded to the depth and realm of feedback that was provided by the young participants:

> "*Well, obviously student nurses are interacting all the time in practice with children, young people, families etc. But you don't get active feedback on your caring skills, your communication skills, how you deal with a situation, a problem. A family might say, 'thank you for looking after me, you've been really good' but you don't get 'I want to tell you about this thing that you did' or 'let me tell you what it was about that that was good', they don't get that. So this is a realm of feedback that is in more depth than they would normally get…And it's different to in-depth feedback you would get from a mentor as well*" (Sam)

Here, Sam identified specific aspects of the feedback that the young participants provided and recognised that it would be unusual for student nurses to receive this in practice. The lecturer also recognised the valuable contribution that the young participants made to the debriefings and that they made a difference to the student

nurses. In agreement with the student nurses, they noted that the feedback was more in-depth than what would be received from a mentor in practice. This suggests that in simulation a deeper and more comprehensive amount of feedback should be provided, which would ultimately have an impact on the learning experience of the student nurses. This is in keeping with the model of 360 feedback (NHS Leadership Academy, 2018), whereby feedback is gathered from more than just a supervisor or manager. It can include feedback from colleagues (experienced and junior) and clients/stakeholders. Thus, in this simulation session the student nurses reflected on their actions whilst receiving feedback from the facilitator and young participants:

> "*It's all right; we know we can do it. The young people said we can do it*" (Claire)

> "*Because you go in and you are so nervous, you think oh I'm going to do absolutely everything wrong, and then they actually boost your confidence a bit and give you some positives*" (Florence)

> "*I think for me, because obviously it was reassuring for me hearing that feedback, it's probably going to make me think when I'm in practice that I'm not as bad as I think I am and reflect when I go through the feedback when I get home and things, it will probably bump my confidence up a little bit more with how I am communicating and interacting with patients that I come across. That will definitely help when I'm in practice*" (Heidi)

> "*Yeah, it was more reassuring…because when I came out, I felt like I did everything wrong, but they said, 'No, you did this, you did that' and I was like…'Oh yes, I did do that, that was quite good', so I found that debrief very helpful*" (Sajeeda)

> "*I think, for me, I would have the confidence now to go up to a teenager and speak to them. Because I think…any teenagers that I have been around, I act really shy because they are nearly adults, so it's completely different communication to what you would speak to a three-year-old or…So I think now it's going to give me the confidence in practice to go up and start speaking to teenagers, knowing that what I am doing is all right, and how I do communicate with them is right*" (Paula)

Hearing the feedback from the young participants was a significant factor at play, which in turn informed their interpretation of their experience as a benefit in that it improved their confidence. The student participants felt reassured about their practice in relation to their interactions and communications with young people in practice. This was an unexpected but positive finding. From this, I contend that had the young participants not been able to express their agency this would not have occurred.

I had not previously considered how this experience would benefit the student nurses in terms of developing their confidence, especially in relation to their communication skills. Developing confidence and competence is commonly referred to in nursing as essential for student nurses (for instance, see Chesser-Smyth & Long, 2012; Lundberg, 2008), with simulation also identified as a method for developing the confidence of student nurses (examples include Edwards, Burnard, Bennett & Hebden, 2010; Kukulu, Korukcu, Ozdemir, Bezci & Calik, 2013).

For now, most of the student participants reported benefits from the involvement of the young people. This seemed consistent even in the case of one student who felt that she had not performed well. In the debriefing, she identified this:

> "*I personally felt like I didn't do very well*" (Jackie)

Jackie felt as though she had not performed well in the debriefing, and two lecturers present during the simulation session had observed this and told me how the young participants had responded:

> "*One of the student nurses had a difficult time in the simulation and she was feeling a little bit unsure of how she'd done, and it was lovely that the young person really picked up on this and really tried to give her some really positive feedback*" (Danny)

> "*I thought they were reassuring to the student nurses who felt they hadn't done as well. I thought they offered a lot of reassurance. And I think they had some empathy with the student nurses…almost roles were reversed, weren't they? Where the younger person was supporting the student nurse*" (Pat)

Here, Danny and Pat identify that the young participant provided reassurance and empathy in the debriefing. This brings into sharp contention the notion that an older

person in a situation such as this would support a younger person. However, this was not the case here; the young participants clearly offered reassurance and support to the student nurses. Once more, this would not have been possible had the young participants not been positioned as the central players in this work. As a young participant noted in the debriefing and interview:

> "[Debriefing]…*I think with yours…it is not you that was the problem, it is the experience you have had…So it is not like you have done anything wrong or you have not done the right things, because you have, it is just the experience that you have not got*" (Sarah)

> "*Yeah, I felt really bad for her. I felt awful. But I think with her it was just a case of it wasn't her, it was her experience*" (Sarah)

While acknowledging that she felt "bad" for the nursing student, Sarah offers a sophisticated insight into why the nursing student might have felt this way. She recognised that limited practical experience of assessing a person with asthma may have affected her performance. It is clear from these comments that the young participants had been able to reassure the student nurses, which was demonstrated by their thoughtful, considered and sensitive approach to giving feedback in the debriefing. According to Gray and Smith (2000) student nurses' value consistent and genuine feedback. Further, Aston and Hallam (2011) suggest that the provision of honest and effective feedback requires a tactful and compassionate approach.

To summarise, it appears that the young participants were able to share their voices with the student nurses. It is evident that involving the young participants in the debriefings was valuable in terms of receiving feedback from a young person and/or service user. This would not have occurred without the young participants having the freedom to act on their decisions. They had engaged in an activity that empowered them with a feeling of mastery, whilst identifying that they were able to make a difference to the learning experience of the student nurses. The student nurses valued their feedback, not least because they were more accustomed to receiving feedback from lecturers, practice staff or parents. However, the experience of involving the young participants in the scenario was beneficial to the young participants and empowered them; there were occasions, however, when their involvement was challenged.

5.5   Challenging voice

There were several instances when the young participants and student nurses talked about being worried or scared about the feedback process. It is accepted that resilience is promoted through the acknowledgment of the advantages of adversity, in addition to experiencing the damaging effects (Newman, 2004). Although I did not intend to provide the young participants with an adverse experience, being involved in the delivery of feedback was a challenging experience for some. As noted earlier, I had worked with the young participants to develop their skills in delivering constructive criticism; however, I was uncertain how this would play out in the debriefings. The young participants spontaneously brought this to my attention in one of the focus group discussions:

> "*I think we were a bit nervous even though we were only giving the student nurses feedback, but they're really nice and they take on board what you say to them*" (Lexy)

> "*I was a bit nervous…if you had to write anything negative down because you didn't know how they would take it*" (Sarah)

> "*It was nerve-racking because obviously you've never met them, but they all seemed like they really wanted to know your positives and negatives about their performance, obviously, because they want to improve on it…Because…we'd never met them and they'd never met us. But they were very mature about it. They were glad we were giving them feedback*" (Sarah)

> "*I was quite nervous because…I didn't want it to come across we were criticising them on what they were doing*" (Louise)

Here, it is evident that the young participants felt nervous about providing feedback. However, they seemed more concerned with having to provide negative feedback. Still, I now realise that their feeling uncomfortable did not precede a negative outcome, but quite the opposite. Newman's (2004) work on building resilience is useful here. He states that exposure to adverse and challenging situations helps young people develop coping strategies, which in turn builds their resilience. This seems to have been the case in this work.

There seemed to be other factors that, although difficult to fathom, were important regarding being in a position of knowing:

> "*I'm not a nurse…I'm only in college and I need to tell someone who is in the third year of nursing who actually knows what they're doing that maybe you've missed 'this',* [it] *was a bit nerve-racking*" (Heather)

The term 'only' stood out to me here. It appears that the young participants had positioned themselves differently from the university students, insinuating that there was an informal but accepted academic hierarchy at play. This was an unexpected finding. My intention had been to position the young participants as experts on other young peoples' lives. Whereas I acknowledge that no single young person or group of young people can speak on behalf of all young people, I accept they are closer and more experienced regarding the lives of other young people than I am. However, using the word 'only' suggests she was questioning the validity of her own views, not as a young person but as a less knowledgeable student. It also became clear that the young participants' position as college students was not the only structural factor influencing them. Their age was an additional structural factor. Another young participant offered a further perspective in relation to the provision of feedback:

> "*I felt nervous because they're all older than me and they're in the position that I hope to be in. So it was nerve-racking. I didn't really want to say bad stuff because they're way ahead of me…they had to be obviously good to get into the Salford as well…I mean they're not higher but, yeah, higher above…we're still only college students and they're at university going to third year*" (Melissa)

Again, I had not considered this or the impact it may have when I started out on this research journey, but, as I became increasingly sensitive to this as an issue, I also understood that such factors had influenced the thoughts of some of the student participants:

> "*Because a lot of them maybe want to be nurses, so we're a bit maybe up from them and they might look to us, so a bit intimidating*" (Julie)

In addition, another young participant thought the students might perceive the provision of feedback from young people as condescending:

"*I think it felt a bit patronising because…having to feedback on what they'd done, because if that was how they were when they were on placement, I didn't want it to be like a confidence knock if we said it seemed like you could have done this*" (Melissa)

One of the student nurses acknowledged this too; she had felt like this initially but on reflection had realised the benefits of the feedback:

"*At first I was a bit worried when I was like 'oh there's going to be young people watching us and saying this is what this should be like and we're looking for this and we're looking for that'. I was like, it's a bit patronising isn't it. College students trying to judge what a student nurse should be like, but that's not what I felt like afterwards*" (Florence)

As the aim of this study was not only to involve but also to privilege young people, I had not previously considered that there could be such feelings; in other words, a perceived 'pecking order' of college students and university students. However, this pecking order was not stable; rather, it represented shifting perspectives and positions. It seemed that the young participants shifted from being experts (on the lives of other young people) to novices (not knowing about nursing and students of nursing), while at the same time the student participants shifted between knowing more and knowing less than the young participants.

For me, this emphasised the need to scaffold and offer strong support in future work such as this. Here, work by Vygotsky (1978) is useful, such as the concept of the zone of proximal development. In future work, I would need to consider how the young participants may need support and guidance from those more knowledgeable and experienced to feel comfortable in delivering feedback. As discussed in Chapter 4, it was essential that the young people received adequate preparation to feel comfortable in providing feedback and that this would provide them with a sense of mastery with the confidence to speak openly with the student nurses. One of the young participants told me how they felt about observing and giving feedback:

"*See, I'm not really used to observing people, and that's watching for the feedback as well. I was nervous at first to give feedback, but then I realised they're going to need it if you're to progress*" (Melissa)

There was then a recognition that, although she was not experienced in observing people and giving feedback, feedback was essential for the progression and development of the student nurses. She had come to know the significance that her feedback could engender. This showed her insight that her contributions would make a difference to the learning of the student nurses. Such benefits were discernible. Newman (2004) identifies that making a difference to others is a strategy that helps build resilience. Although I am unable to fully claim that this was the case, the student nurses reported that they valued the feedback and, as a result, it made a difference to their learning.

However, the lecturer participants were not as sure:

> "*I think it comes down as well to the personality of the young person, whether they are outgoing, whether they have the confidence to speak in a group that is new to them, and some of them, I don't know, they may have felt like they were able to do that, but you put them in the situation and they may have felt a little bit kind of lacking in confidence and being able to express what they thought, or, they may just have thought it was all good and felt like they didn't have a lot to say*" (Sam)

However, the young participants understood this differently. It seemed they were taking account of, and picking up cues from, the student participants' behaviour. One young participant explained why she had not offered more feedback:

> "*There was a lot of things felt like I needed to hold back on. 'Cause I know I didn't want to say anything that they did bad because they were already nervous…so I felt I didn't give enough feedback…I know for the future to give more constructive feedback and then for the bad points, so turn them around in a way*" (Melissa)

As Melissa was the only young participant to express this view, I had asked her to elaborate; she told me:

> "*You said they did an assignment on asthma. So I thought they'd be a lot more prepared than they actually were…So that's why I wanted to say…but I didn't know how to say…you weren't prepared…in like a really nice way*" (Melissa)

In hindsight, perhaps I should have explained to the young participants that not all the student nurses had worked with a young person with asthma in practice. This means some were relying on taught rather than experiential learning, and this could make a considerable difference with regard to their performance in the simulation sessions.

In summary, there was a shifting relationship between the student nurses and young people. Whereas at times this related to structural factors such as age and their being college or university students, it also related to the value the student participants placed on feedback from children and young participants and the young participants' view of themselves as being more expert on young people's lives. However, there were more factors at play. For instance, I became aware of the constant interplay between the different people involved and the work needed to find a balance for everyone involved. As one lecturer noted:

> "*You want the young people involved in the feedback to be comfortable, and if they are only comfortable saying a limited amount then you don't want to force it out, do you? But I think that the more feedback students get the more benefit they get from the experience. So, I think that the more vocal ones in the morning, that was really useful for the students*" (Sam)

She had discerned a difference between the two groups of young participants. One had been very quiet, and there was a difference between the amount and depth of feedback they provided and that from the other group. There are a number of possible explanations for this, such as them lacking confidence, lacking knowledge and being unfamiliar with the environment. It seemed there was a balance to be struck between scaffolding the young participants' ability to give feedback and making sure they never felt pressured into giving feedback with which they were uncomfortable. Another lecturer concurred:

> "*the young people that were with us didn't contribute as much. They were much quieter, maybe not as confident*" (Danny)

Both Sam and Danny were present for the morning and afternoon simulation sessions. From their accounts, they had noticed a marked difference in the feedback provided to the students. However, Pat, who had been working with a different group of young people, offered an alternative perspective:

> "…*I think, given the situation, given the length of time that they* [the young people] *had and the conversations that I had with them, they were able to vocalise more things and their confidence was growing…*" (Pat)

Given this, I reflected on the potential that further experience and involvement may bring.

However, it is possible that other factors were at play. The debriefing part of the simulation sessions involved two lecturers, two student nurses, three or four of the young participants and myself. On reflection, I wonder if this was too challenging, perhaps even intimidating. Feeling uncomfortable in this situation may have had an impact on the young participants' confidence. However, challenging situations can assist with resilience. Had the young participants not been involved in this final part of the simulation session, their opportunity for growth might have been diminished.

Another lecturer made some suggestions about how some issues regarding the depth of feedback provided could be overcome:

> "*I think maybe it's about not cherry-picking but having some idea of how articulate, how confident the young people are going to be at actually giving that feedback, because you can see that it would be really useful to the students if it was done in the right way*" (Danny)

Such views are consistent with the notion of involving competent, articulate and more able young people in such work. However, such selection would have been counter to the values underpinning this study, namely, inclusivity and inclusion regardless of capacity or capability. On reflection, as noted in Chapter 3, these principles had been challenged by the curriculum leader.

To summarise, there were times when the voices of the young participants were challenged. This included the young participants feeling nervous about delivering feedback to the student nurses and how they perceived their position and age as college students.

5.6   Personal development

Involving the young people in simulation was an extracurricular activity that added value to their existing college studies. This was not a mandatory activity, and the

young people's involvement was voluntary. One of the objectives of this study was to understand the outcomes and impact of their involvement. In the next section I present the findings that relate to the additional knowledge and skills they gained from their involvement in the research and how this contributed to their personal development.

In their interviews, the young participants told me about their experiences of working with me and the student nurses:

> "*I think it's made us all stronger as a group. We've all had to work together in different aspects of it, but then working together we've been able to allocate roles and things like that so we've all had our fair share in it all. I think it's built up teamwork and things like that*" (Louise)

> "*I think we've developed skills…I was the voice, I was nervous. But that was good. I liked doing that. It was a confidence booster. I think it's been nice taking part in a group because some of those people…we didn't even know, we had to get to know them as well…So that was good*" (Heather)

It seems that the young participants identified a number of benefits from taking part in the study. Key in this were working cooperatively and negotiating with each other to complete the activities. Many expressed the view that their involvement had resulted in a positive effect on their confidence.

The young participants also talked about how participating in the simulation had helped with their decisions about their future careers:

> "*It's going to help with my UCAS forms when I go to uni*" (Amelia)

> "*Yes, saying it'll help, obviously it's something extra…some people won't have this on the UCAS form. Like the ones that have done this, that research…you have something extra and it'll look better and also* [the research was done] *at a university as well*" (Chelsea)

> "*I know it'll look good on your application but it's not only that…especially during your interviews as well. You can actually speak from experience of what, that you know what's involved in some of the training*" (Melissa)

Here, the young participants recognise the significance of participating in relation to enhancing their UCAS applications and prospective interviews at universities. They felt that they would be able to use this to their advantage and that it would demonstrate that they were committed and would stand out from others. In addition, the curriculum leader made a similar comment:

> "*They get to see that this is good and get involved in something and it's built their confidence up. They feel like they've been part of the second-year nurses module, and for you to trust them with that…and it's something that they can put on the UCAS form, something that they can say that they're proud of*" (Diane)

Undertaking extracurricular activities can enhance a CV or application form, more notably when the activity is specifically related to the programme, course or position being applied for. Kirby (2004) suggests that involvement in research is beneficial in terms of using the experience to enhance CVs for future employment or education. The young participants were 'proud' of their participation and felt rewarded for their efforts. In addition, they would be able to include the knowledge and skills gained during their participation.

Some of the young people recognised some additional benefits from participating in the research:

> "*we looked at the qualities of being a nurse. And we all want to be nurses so it's nice to see that other people think this as well, and how that can be useful for nursing*" (Heather)

> "*It* [the simulation] *shows how children and young people nurses actually work in a hospital environment…it shows how I'd have to act in that kind of setting as well…it's also benefited me because I want to do children's nursing*" (Chelsea)

> "*Was good to be involved…because I'm going to be doing nursing as well…I know it's not going to be children's nursing, it's going to be adult but I'll still probably have to do scenarios, and it was good to actually speak to the* [student] *nurses as well…and find out how hard it can be and stressful parts*" (Melissa)

> "*It's good to get like an insight on what you could be doing if you chose that when you went to uni*" (Sarah)

Here, the young participants recognised how the experience of being involved in the study provided them with an insight into nursing and higher education. I had not anticipated this as an outcome for the young people, and, although unintentional, it had positive consequences. The group exercises enabled the young people to discuss the qualities that make a good children's nurse. Observing the student nurses gave them an insight into nursing and their future career choices.

The student nurses talked to the young participants about certain aspects of the programme, and more specifically, at times, that it was a difficult and stressful course. I recalled that this occurred when the young participants first met the student nurses. There was an opportunity for the young participants just to have an informal chat with the student nurses, and the intention was so that they were familiar with each other; I had not expected them to discuss the programme.

Some of the other young participants offered another perspective on their insights:

> "*It shows how the university does things through the nursing and the different areas they go into, and it just shows how good the university is…I think that we've just benefited from the actual experience itself…getting the feel of university and the feel of practice*" (Chelsea)

> "*It gave us an insight as well of what to expect. Even how the lecturers are*" (Jenny)

> "*Yeah it was kind of like…different to college*" (Amelia)

The experience had helped them develop a better understanding of university life. Being exposed to a university setting was beneficial for the young participants, as it could assist with their transition from college to higher education. Porteous and Machin (2018) conducted a phenomenological study exploring experiences of transition into higher education with 30 first-year undergraduate nurses. Their findings suggested that there are significant challenges for first-year students, namely, uncertainty, expectations, learning to survive, seeking support and moving forward. The young participants in the study reported here suggest that their involvement had given them an insight into higher education and the nursing

profession. Thus, it was hoped that this involvement would assist with the transition to higher education and minimise the feelings reported by the student nurses in Porteous and Machin's (2018) study.

There were additional benefits for them. Diane explained when I first met her that the young people do not often get asked to get involved in extracurricular activities and that when I approached her she felt privileged. In a later conversation she discussed this in more depth about how health and social care courses are often less recognised and have fewer opportunities to shine.

Although this had not been one of the aims of the research, it was pleasing to hear that Diane felt that the project had been beneficial for the college and the young participants and it was valued by Diane as an extracurricular activity. In keeping with national organisations aiming at improving social mobility and ensuring that young people are given the opportunities to progress into higher education irrespective of their background, geographical location or school (Brilliant Club, 2018; Sutton Trust, 2018), it was hoped that this study would assist in helping the young people transition into higher education. Diane also told me about how she thought being involved had benefited the young people. She suggested that they might not be as frightened of University and that those who worked there were 'normal' people.

One young participant explained how it felt being in the University in relation to how fast-paced it was and the number of people around:

> "…*there's so many more people, it's like you have to get into it kind of thing, you have to get into the flow of things and it's so different to college. There's not as many people…you're all right with college, but then with uni it was…oh, take a breath…it was harder to take it all in*" (Chelsea)

> "*And knowing how that simulation, how it's all, it works and what they do and how they do it, why they do it to test you and things like that…when you are doing simulation yourself it's a bit more relaxing when we have to do it next*" (Louise)

Young participants can experience significant challenges when transitioning and integrating into higher education (Porteous & Machin, 2018). The young participants expressed uncertainty about integrating into higher education and the nursing

profession, and prior to participating in this study they were uncertain about what to expect.

As explained in Chapter 4, the young participants engaged in workshops with various activities to develop an HFS scenario. The young participants identified various benefits and advantages for them following their participation in the simulation and research project and evidently viewed the experience of participating as positive. In addition, the student nurses and lecturers corroborated the views of the young participants, stating that their involvement was valued. As Newman (2004) identified, involving young people in extracurricular activities can assist with building resilience. The young participants in this study discussed further benefits, such as developing teamworking skills, confidence, gaining an insight into nursing and overcoming their fears or misconceptions about university. In keeping with NCB (2010) and Kirby (2004), involving young participants in research can significantly enhance their personal development in terms of increasing confidence and self-esteem.

5.7 Summary of chapter

In this chapter, I establish that the involvement of the young participants had benefits for them and for the student nurses. Whereas the young participants reported that they felt listened to through their involvement in the activities, the student nurses valued the unique contribution that the young participants brought to the HFS sessions. I argue that through their involvement in developing the simulation scenario, feedback tool and delivery of feedback they were able to find and share their voices. However, there were some instances when their ability to voice their opinions proved difficult for them. That said, in addition to feeling valued, there were other discernible benefits. These included gaining an insight into higher education and the nursing profession and developing confidence.

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Chapter 6

Findings (2)   Creating a more authentic reality

6.1   Introduction

In this chapter, the second concept is presented, namely, creating a more authentic reality. Authenticity in simulation featured as a prevalent concept from the analysis and synthesis of data across all sources: young participants, student participants and lecturers. All expressed what they perceived to be 'realistic' or 'authentic' when participating in a simulation session. The concept of authenticity in simulation is not new; however, enhancing or optimising this through the involvement of young participants is proposed as a new finding. Four themes constituted the overarching concept of creating a more authentic reality, namely, *realism of simulation scenarios*, *'being' the voice*, *learning to build relationships* and *learning from difficult situations*. In this chapter, I provide evidence from the analysis to show how the young participants, as social actors, represented and constructed a world familiar to them through involvement in simulation. Along with providing a meaningful experience for the young participants, I contend that their involvement created a more authentic reality for HFS sessions.

6.2   Realism of simulation scenarios

As discussed in Chapter 4, the simulation scenario was designed by the young participants with minimal support and direction. This involved them participating in workshop activities through which they constructed a world with which they were familiar, participating as social actors and agents (James & Prout, 1997; Mayall, 2002). In the workshops I discussed the outline of the simulation scenario with the young participants, which focused predominantly on the physiological aspects. This was to ensure that the clinical presentation, treatment and care were accurate and applicable to the practice setting. The young participants were then supported to develop the social history and background to the scenario independently, although they were invited to ask me questions. The young participants wrote all the background and context for the case scenario. I had asked them to consider, for

instance, a name for the girl in the scenario and details about her family, her hobbies and her personality and suggested that they should be creative, whilst still maintaining a realistic approach. I asked them how they felt about participating in this aspect of designing the scenario:

"*That it was a situation like someone our age would actually be in*" (Lexy)

"*Yeah it was good. Being able to write the 15-year-old…and the characteristics*" (Amelia)

They recognised that their ideas and thoughts provided a realistic context and case. In keeping with the notion of children as social actors (Wyness, 2015), the young participants were actively constructing a world that they felt comfortable with.

Another young person talked to me in more depth about this experience:

"*I think coming from us, and because we are young people, we know how they would kind of act, we were saying she was moody with her dad and she'd give backchat about the party and stuff. We would probably do that if we knew we had plans, or because we always think we're right and Mum and Dad are wrong, you always argue back. So, we could make that scenario more realistic than if older people did it…we came up with a scenario which was more realistic than if anyone else did it*" (Sarah)

Here, Sarah demonstrates an insight into how their input into writing the simulation scenario was important and that their contributions enhanced the realism of the simulation sessions for the student nurses. Her use of the term 'realistic' is important here, as she is drawing on her knowledge and experience of the relationships between young people and their parents. Although she does not state specifically that she is referring to her own relationship with her parents, she is able to provide an insight into how a young person would react and behave with their parents. Her words suggest that involving young participants in the development of the simulation scenario enhanced the perceived authenticity of the simulation sessions for the student nurses. In addition, she demonstrated her understanding of the different perspectives that young people and their parents would bring to a similar situation. This understanding is consistent with the notion of children acknowledged as 'beings' rather than simply on the road to 'becoming adults' (James et al., 1998; Prout, 2005;

Uprichard, 2008). Work by Uprichard (2008) is useful here. She suggests that the 'being' child is considered as a social actor, constructing his/her childhood. The 'becoming' child is viewed as deficient in competencies of the adult that he/she will become and is considered an adult in the making.

The student nurses discussed how they felt about the simulation sessions and how they related to practice:

> "*It was a bit challenging, but it was good. It wasn't a really easy, compliant thing, it was a scenario that could happen, and it was just to challenge us a bit*" (Julie)

> "[Debriefing]*…It seemed really realistic didn't it, the actual scenario itself, and that does happen on wards, children do deteriorate really quick, so that was really good*" (Florence)

> "*And the boyfriend and the car and it was a very realistic scenario that you would encounter in practice. It was well thought out, it was well written I thought*" (Andrea)

> "*I think obviously from the young people's perspective I think it was probably quite realistic. You have conflict with parents, what teenager doesn't have conflict with parents?*" *(*Ameera)

It appears that the student nurses were able to make a comparison with practice, expressing that they could encounter such scenarios whilst on placement. They recognised that working and communicating with young people can be challenging and that the simulation reflected the complexity and reality of everyday practice. They discussed the issue of the boyfriend in the car and the ensuing conflict with parents, a situation that they had experienced in practice.

The student nurses agreed that the involvement of the young participants in designing the scenario facilitated an authentic simulated learning experience. In addition, they concurred that had a lecturer written the scenario it would have been less realistic. Thus, the role of the young participants was significant:

> "*They* [young people] *set the scenario…so it wasn't like you'd set it, it was an actual adolescent, so it was more realistic*" (Claire)

"I think because, lecturers know, they've experienced all this before, and so they know the scenarios that could happen, but when it's a real person, it's…I think it's a lot more realistic" (Julie)

Here, the student nurses highlighted the significance of the young participants' contribution to the design of the simulation scenario, comparing it to when these are written by lecturers. There was a suggestion that had a lecturer written the simulation scenario it would have been based on their existing experiences and knowledge and presented a contrived or biased context. As a lecturer facilitating simulation, I would often design scenarios based on my previous practice experiences. Although such experiences occurred over ten years ago, I had always considered these to be credible in terms of providing a realistic scenario. However, involving the young participants in developing the simulation scenario strengthened its credibility. In turn, I contend that this process disrupted the more usual approach to the writing of a simulation scenario. Here, it is recognised that the young participants were social actors in constructing the scenario for the student nurses within the constraints of an adult world. That is, lecturers are usually those who write and design simulation scenarios and hence they are produced through an adult lens.

It appears that the student nurses recognised the significance of the young participants' involvement in writing the scenario and used the word 'realistic' to describe this. Through their writing of the scenario the young participants disrupted my own and other lecturers' usual way of writing a scenario. In my role, I would bring an adult-orientated lens to the scenario, which was likely to be likely to be viewed from the perspective of and biased towards the needs of the parents and the physiological needs of the young person. However, working with the young participants, their meaningful involvement invited a disruptive force, but, as opposed to having a negative impact, this proved beneficial.

The lecturers too had noted the benefits that the young participants brought to the writing of the scenario:

"I really liked what they'd done in terms of setting up this background of her having this asthma but her boyfriend's a smoker, her dad doesn't like her boyfriend, it just felt really realistic and I don't think we could have done that in the same way. As much as we are engaged and know the age groups that

we work with, it's not like being at that age and being able to think from their unique perspective, so I think it made for a much richer scenario in a lot of ways. I really do see the value in the scenario writing…actually getting that user carer perspective is a unique perspective" (Sam)

"*I think they were able to grasp things like the boyfriend, the smoking, the angst of being a young person in an adult world, trying to deal with adult issues. I think they were pretty good at representing that for a child that's in bed, so it wasn't just an asthmatic in bed, there was a history, a context, and I think they added that to that scenario. They were able to give that life view…of an adolescent…Instead of us projecting on them what we think a teenager would be experiencing*" (Pat)

"*The social history and some of the detail they'd done about the boyfriend was very good as well, and they probably put things in therewhich we wouldn't have done as adults because we kind of…or maybe some lecturers do, but I think perhaps from my perspective I'd come from it from my angle and my age and probably more as a mother and I think I know what teenagers are doing when actually I'm probably completely unaware of what teenagers are doing*" (Chris)

In keeping with the views of the student nurses, the lecturers identified the significance of the young participants' writing of the scenario, recognising that the young participants know more about the lives of young people. They confirmed the importance of not imposing their own thoughts and opinions on the simulation scenario. Here, the lecturers recognised a shift in their position and the important lens that the young participants brought to the scenario.

In addition, the lecturers' opinions aligned with those of the young participants and student nurses in terms of the value and added benefit that the young participants brought to the simulated scenario. The lecturers suggested that the young participants enriched the scenario by constructing it from their own perspective and described it as a "unique perspective". They added that it was valuable to ensure that a lecturer did not project their own views on how they think a young person would act or how the simulation sessions should be enacted.

When designing the social background to the scenario, the young participants were asked to provide details such as names (including those of parents), hobbies and school subjects. The young participants agreed that the young person in the simulation should be called Elizabeth and were specific with some other details:

> "*What was amusing was the detail they added to it. And so, you know, being in the boyfriend's car, yeah, okay, we could…maybe we'll come up with that one. But it was quite…I just found it quite amusing that the names they chose for the characters were kind of very odd and the hobbies. Very random, you know? Oh…she's a Morris dancer*" (Danny)

> "*I thought the names were hilarious. In that they were almost stereotyped older and younger names*" (Pat)

Here, the lecturers made some very specific comments, which surprised me, regarding the context and demographic information that the young participants had created. In their accounts, they referred to some of the details as 'amusing', 'hilarious', 'odd' and 'random'. Hopkins (2010) suggests that adults may have perceptions about young people, which may include fears, assumptions or stereotypes about the expected attitudes and behaviours of young people, including the role they should play in research. Perhaps the young participants had intended to embed some humour into the scenario, although I cannot recall that this was their intention. However, I had proposed that they used their creativity and imagination.

During the interview I informed the lecturers that some of the hobbies that the young participants had chosen for 'Elizabeth' were in fact their own and that they were applying their own genuine and personal interests to the scenario. The comments from the lecturers made me consider again how young people are constrained by adult perceptions. In my day-to-day practice, it would be not only adults (lecturers) but also qualified children's nurses, many of whom are also parents, that would formulate the context. Here, the young participants had disrupted and thwarted this usual way of working and transformed what would normally be an adult-derived context into one close to the emic perspective of the young participants. I had unwittingly acted in accordance with Lee (2001) by facilitating the young participants to challenge the accepted wisdom of the nursing lecturers and acted against

convention in order to bring about change. This was also brought to light through the role that the young participants played in providing the voice of the manikin.

6.3 'Being' the voice

It emerged that it was not only the contextualisation and understanding that the young participants brought to the writing of the simulation scenario that benefited the student nurses. Their being the voice of the manikin was also implicated in the creation of a more authentic simulated experience. As the voice of the manikin, the young participants reacted and spoke to the student nurses according to their interpretation of how a young person would feel if they were in hospital. They were able to express their feelings, thoughts and anxieties in a way that made sense to them.

Providing the voice of the manikin was a role that the young participants volunteered to undertake. This was another opportunity for the young participants to use their own words and ideas and the freedom to make decisions. It seems the young participants had enjoyed working as the 'patient's' voice, and they explained how they had, at times, forgotten that they were acting:

> "*It sounds really stupid, but I forgot that there was a manikin there. It felt like I was part of the scenario, but I wasn't. I wasn't having an asthma attack or anything. It felt very real and I think that was good*" (Sarah)

> "*It felt really natural. As if I was in that bed, even though I wasn't. Felt like my mind was, because they asked me what I was doing in school, obviously it wasn't actually me, it was the scenario. But I knew what I needed to say to the student nurses…they were like having a conversation*" (Louise)

> "*It was like having a conversation with someone, but they didn't know who you were. Because the conversations weren't awkward between the student nurse and the patient in the scenario, it was easy enough to come out with something to say to them*" (Louise)

Here, and in keeping with Wyness (2015), the young participants appeared to be immersed in their social world, with the ability to develop a relationship between themselves and the student nurses. They had felt able to participate in the simulation

scenario and talk to the student nurses about what was important in their lives. The young participants identified that the conversation felt 'natural'. I maintain that this was because they were involved in representing and constructing a situation that felt familiar to them. The student nurses concurred with how the young participants felt about having these conversations:

> "*After a couple of minutes, I forgot that it was a manikin…At first it was a bit strange and…but then because she was responding so natural, it just felt natural after*" (Julie)

> "*Yeah, I did. I started to feel like it was real*" (Mandy)

> "*Because she was saying like real-life things as well*" (Sandra)

> "*Why are you doing this, and can I go home now and…it was challenging to respond because you've just got to respond there and then, and usually you've got your mentor there and she'd usually respond for you, do you know what I mean? But to have to do just think on the spot…it was good to learn how to kind of deal with those situations*" (Claire)

Here, the student nurses recognised that the simulation sessions enabled them to develop their learning, more specifically through the involvement of the young participants as social actors. It appears that the student nurses were challenged by the young participants, more so than in practice. As a result, however, they had the opportunity to develop their communication skills, as they were required to think independently without the support of a mentor. This was an important component of the simulation sessions, as one of the learning outcomes was to communicate effectively with the young person. From the findings I propose that this was better achieved through the involvement of the young participants.

Synthesis of the data led to the identification of how realistic the conversations were that occurred between the young participants playing the voice of Elizabeth and the student nurses. Across all data sets, the participants referred to the conversation that they either contributed to or had observed between Elizabeth and the student nurses. As for the young participants, they alluded to becoming immersed in the scenario and forgetting that they were providing the voice of a manikin. They referred to feeling like they were having a 'real' or 'natural' conversation with someone. They

stated that they felt like they were lying in the hospital bed where the manikin was situated, as opposed to providing a voice from behind a glass window in the control room. The lecturers also identified the challenging nature of the conversations between the student nurses and young person:

> "*I heard the young person doing the voice, I actually thought initially, is she pushing them a bit too hard, because she was being very uncooperative to treatment and really questioning, questioning, questioning the student nurses…I still think that was an authentic situation because some young people are really uncooperative and that's just how it is*" (Sam)

This was an interesting reflection from Sam, as it seems that he/she felt like he/she needed to 'protect' the student nurses. Sam recognised that this young person was particularly challenging and, at times, that she was pushing the student nurses too hard. In the next chapter, the notion of psychological safety in simulation is further analysed, and perhaps Sam was conscious of ensuring that the student nurses felt safe and supported. Thus, not only were the student nurses learning from the simulation, so were the lecturers. In keeping with the concept of 'double-loop learning' (Argyris, 1991), Sam was required to stop, reflect and change her understanding of the situation.

The simulation sessions were streamed live to another room so that the young participants could observe them. Some of the young participants talked about what they had observed:

> "*I think you kept the conversation going, you kept putting in new things, what they had to deal with, how you were talking and how you were acting*" (Jenny)

> "*It* [the conversation] *just flowed, like she was in that position. It wasn't like she was reading off something…she knew what to say but wasn't rehearsed*" (Louise)

Here, the observers stated that the young participant providing the voice of Elizabeth was successful in portraying the role. More specifically, they referred to the young participants' ability to keep the conversation flowing naturally without the use of a script and that each conversation varied with the different student nurses. The ability to have a natural conversation between the young person providing the voice of the

manikin and a student nurse was therefore not only identified by those experiencing the conversation but also noticed by those who were observing.

In addition, the young participants made observations about the conversations that occurred between the father and daughter in the simulation sessions. One young participant reflected on her role and the conversations that she had with her 'father':

> "*He* [the dad] *was spot on…I could imagine my dad actually being like that. You know…especially the Netflix and iPad, it was like 'no you're grounded'. That'd be my dad as well, so he really went for it…it was actually like a dad/daughter kind of relationship, the way he spoke*" (Melissa)

Here, she identified that the relationship between the daughter (the young participant playing the voice of Elizabeth) and the father appeared realistic. In keeping with the notion of young participants as social actors, it appears that she immersed herself into a social world that she was familiar with, namely, the relationship between a parent and child. However, for one of the young participants, this element of the simulation session did not come as naturally to her:

> "*That was difficult…I'm sure I had an attitude with my parents at home, but trying to show that attitude to someone who has not actually ever annoyed me, because I've never met him before. I thought it was a nice touch on making the scenario realistic*" (Heather)

Here, Melissa disclosed that she found it difficult to 'act' in such a way as to annoy her 'dad'. The person playing the role of the father was an academic member of staff. The young person providing the voice of the manikin had met him quite briefly a few weeks before and on the day of the simulation itself. Although she appeared familiar with the situation, she seemed to be struggling with revealing her 'attitude' and this aspect of her 'self' to those outside her family. This uncomfortable feeling points to her being in a situation that she can identify with, yet she was unable to let this side of her 'self' be revealed to other people. This made me consider that I should have provided more time for this young participant to get to know the lecturer 'dad'. This could have enhanced this relationship and made the young participant feel more comfortable in revealing this aspect of 'self' within the scenario. However, it is

recognised that the young participant did not have any experience of 'acting', which could have constrained her ability to feel wholly comfortable with the role.

That said, the young participant recognised that this aspect of the simulation session (having someone role-playing the father) added to the realism. This suggests that although the young person found communicating with the 'dad' challenging she was able to suspend disbelief and continue to have a conversation that could occur in real life. The notion of suspending disbelief was first described by Coleridge (1817) as being able to overlook the less realistic aspects of fiction. Later, Dieckmann et al. (2007) suggested that suspending disbelief means entering into a fictional contract and that learners must accept that some elements may not be exclusively realistic. However, through the involvement of the young participants in the planning and implementation stages of the simulation sessions, I contend that the student nurses were more likely to achieve the suspension of disbelief.

Nothwithstanding, following analysis of the data, there were some challenges that emerged regarding communication with the manikin. The young participants talked to me about how they thought the student nurses might feel about communicating with a manikin:

> "*It felt more natural to me because they* [the student nurses] *were moving, they were alive, whereas the student nurses probably felt a bit more awkward, not embarrassed, but awkward that they were just talking to someone that's not moving that's talking*" (Louise)

Here, she identified that it was perhaps more difficult for the student nurses to have a conversation, as they were talking to a manikin and not a real person. However, the young participants demonstrated their empathic and sophisticated insight into this by considering the student participants' experience. They expressed how difficult it might feel to be talking to a manikin. A student participant concurred:

> "*I did find it hard to bring up conversation because I felt like I'm talking to a manikin, I didn't know what to say, so there was one point in ours where **** went to get the mask…I was saying, 'I'll be back…I'll just see what my colleague's doing' because I didn't know what to say, what kind of conversation to have. I felt like if I said certain things, I didn't want to be*

patronising to her. I felt like if she was there in front of me and it was me treating her I'd obviously be able to have a different conversation than with a doll" (Heidi)

Here, she had reflected on her experience and was quite sure that she would have behaved differently with a real person in practice. For her, the distance between a manikin and a 'real' patient seemed too great. On reflection, I realise now that this is not an uncommon reaction. Davis et al. (2017) reported that learners may struggle with reality and that their response to a manikin could not be taken as a representation of how they would react in clinical practice. However, the fact that young participants responded as the voice of the manikin was implicated in ensuring that a more authentic reality was achieved.

Other students had expressed similar concerns prior to their engagement in the simulation session:

"*I think that was a big thing before I went in…you think it's not the same because it's a manikin, you're not going to act the same because it's a manikin*" (Julie)

However, on completion of the simulation session their perception had changed:

"*…but it was a lot easier to be natural*" (Julie)

Julie elaborates on how it felt natural for her:

"*After a couple of minutes, I forgot that it was a manikin…At first it was a bit strange…but then because she was responding so naturally…because we had our own conversations that we would naturally have in placement…about watching telly and things…it felt more real because of the responses*" (Julie)

"*I think it just made it a lot more realistic and made me more natural and I felt like I was really in placement…and that it was a real situation rather than just talking to a manikin that isn't real*" (Julie)

Whereas it is appropriate to acknowledge the different views held by the student participants, there was a consensus that the conversation had felt realistic. Similarly, several of the other student nurses commented on how realistic the conversation

with 'Elizabeth' was. Three student nurses exchanged the dialogue below in their focus group interview:

> "*I was surprised at how more realistic the teenagers were doing the voice…it made it so much more realistic than I thought it would be*" (Leona)

> "*She was acting like, well she is a teenager isn't she, but like what she was saying and things, about her hair and that*" (Bridgit)

> "*It was a realistic teenager, wasn't it?*" (Florence)

Here, the involvement of the young participants had enhanced the authenticity of the simulation session for most students, and, as a result, this had a positive impact on their experience and their learning. The conversation had felt real and flowed naturally. The student participants went on to discuss why they thought this had worked by explaining some of the perceived differences between a lecturer and a young person providing the voice:

> "*I think if it was a lecturer that was speaking, I don't feel like I'd be able to ask, 'Oh, did you watch X Factor at the weekend?', because it might not be something that you'd necessarily think that you'd ask a lecturer*" (Julie)

> "*I think, as well, if I knew it was a lecturer, when you were explaining…like she asked me what the nebuliser was…and I think if I knew it was a lecturer, I wouldn't have explained it in the same way*" (Claire)

Here, the student nurses identified the positive impact that came from the young participants providing the voice of the manikin, rather than a lecturer, which, for pragmatic reasons, is often the case in a simulation. Having completed this study, I now agree with Crowley (2013), who reported similar findings. Interacting with a lecturer in a role-play situation may be awkward for a student and could potentially hinder their ability to perform and engage naturally with the manikin. It was evident that having a young person provide the voice of the manikin had led to a more natural conversation. The student nurses were able to talk about issues or topics with which they were familiar:

> "*Yeah, because if it's a lecturer, you think they know more than you, they might be expecting a really advanced answer*" (Julie)

> "*I think the things I'd said back to the teenager…because you word things differently, don't you, and even though you are being in the teenager's body, we'd know it was someone, not a teenager, so we wouldn't say things in that way, would we*" (Florence)

> "*So, I think that was a lot different, because if you'd just walked into a ward today you wouldn't have met them before either, but with you, we've met you, we've seen you and I think if it was a lecturer you know it's a lot different*" (Jackie)

It is worth noting here that the student nurses thought that the lecturers would expect more detailed and advanced answers to the questions asked by the young participants. This is a moot point, which again challenges the established notion of adult lecturers constructing and providing the voice of the manikin. It is possible that a more authentic simulated experience relies on not only the context in which the case is embedded but also the responses answered to questions; in other words, being able to answer questions in a way that was more aligned with how the student participants would answer and respond to questions asked by a young person. The student nurses suggested and understood that this was related to the language they used and their explanations being age-specific and therefore better suited to the specific scenario:

> "*It just makes it so much more authentic, doesn't it, rather than an adult pretending to be a young person. We don't always remember what it's like to be a young person, do we, but they are a young person…it's really accurate so it was good*" (Andrea)

> "*There's no one else better to pretend to be the young person. I really enjoyed the fact that it was a younger person, and it makes it more realistic*" (Jackie)

In my experience, lecturers or simulation technicians usually provide the voice of a manikin for pragmatic reasons. However, the findings here suggest that this is far from satisfactory when the aim of simulation is to provide student nurses with an authentic learning experience. Most of the participants found that the conversations between 'Elizabeth' and the student nurses augmented the authenticity of the scenario. The lecturers agreed:

"I thought their dialogue with the student really flowed. It didn't feel like they were looking for a script, it really felt authentic in exchange of dialogue as such, so that was nice. And obviously the age of the voice, which lent that tangibility to the scenario I think, so I was nicely impressed with actually what it brought to the simulation in a way" (Sam)

"Clearly, the terminology used and the sound of the voice was more realistic, I feel, in terms of representing a child in a bed or a young person in a bed" (Pat)

"I do think it made it more realistic just from the tone of their voice, and you could tell their age" (Chris)

"I think it was a really good idea [a young person being the voice]*…if you'd have had another lecturer it wouldn't have been as realistic"* (Jerry)

Here, the lecturers identified the tone of the voice, the dialogue and the language used by the young participants as implicated in their experience of a more authentic learning experience. They also acknowledged that adults are not always able to recall what it is like to be a young person.

It was apparent that the lecturers recognised this. In particular, they noted the differences in words used, inflection and intonation. The tone of voice of the young person was more authentic, and the language and dialogue used were representative of the young person in the simulation session. In turn, the lecturers identified that it was age-appropriate in comparison with a lecturer in that they could discern a clear difference when a young person was talking as opposed to an adult. In keeping with the views of the student nurses, the lecturers agreed that the young participants' involvement in the simulation sessions enabled a more authentic experience.

However, there was a difference of views when it came to the use of terms of endearment. During one of the simulation sessions a student nurse called the young person 'chick'. The use of this term was discussed in one of the focus groups by the student nurses:

> "*I think…was it *****? Or somebody criticised me on calling them 'chick' all the time, but they* [the young people] *liked it*" (Belinda)

The student nurse recalled that 'Elizabeth' had been receptive to this term of endearment, and this is evident in the debriefing that followed the HFS session:

> "[Debriefing]*…I quite liked that to be honest. That put me at ease. It seemed friendlier because I* [Elizabeth] *had said I was on my own and I was nervous being in the hospital*" (Heather)

Although the young participants seemed to like the idea of being called 'chick', this was perceived differently by the lecturers:

> "*Both the person who was facilitating the debrief and myself had written about perhaps being too informal and the words they used, like 'chick' and 'love', to the patient, yet the young people fed back that they found that really good and that they could relate to them better and it was almost as like that's how they would chat between them and their sisters, but I think we were looking at it from actually, they're not their sisters and they're not their friend, it's a professional relationship*" (Chris)

Here, there is a disparity between what the lecturers and young participants considered as appropriate language. Chris considered the use of 'chick' and 'love' as inappropriate and contrary to professional boundaries. Others have reported such discrepancies regarding the use and appropriateness of terms of endearment with patients (Blakemore, 2015; Comerford, 2015; Harpham, 2010). Whereas Harpham (2010) suggests that certain terms of endearment can enhance the clinician-patient relationship, Comerford (2015) reports that a Care Quality Commission inspection at a care home suggested that such language could be perceived as demeaning and patronising. However, for the young participants, the use of the word 'chick' was experienced as comforting and facilitated a sense of familiarity and emotional safety. This drew me back to the work by Grotberg (1997) and Daniel and Wassell (2002), who propose that people's resilience is enhanced by having a sense of belonging and feeling safe with those around them.

The student nurses explained that adults are not always able to recall what it is like to be a young person. Therefore, attempting to enter young people's world and

become less of an adult is perhaps not possible. This challenges Mandell's (1991) notion that adults can adopt a 'least adult' role to successfully undertake participatory research with children, suggesting that by doing so an adult can slip into a child's social world. Christensen (2004) also challenged this notion, proposing that it was too straightforward.

The contribution that the young participants made as the voice of the manikin was significant. The findings indicate that the voice increased the authenticity of the scenario, and as such the learning experience of the student nurses was enhanced. The young participants contributed to this through their immersion in the simulation scenario and as agents constructed a social world (the scenario) that they were familiar with.

All relationships are challenged and open to contestation. All the participants in this study appeared to be engaged in shifting positions as they tried to balance their individual, subjective real worlds with those of others. It seems that there is much to gain from the involvement of young participants in simulation sessions, not least in enhancing the authentic reality experienced by the student participants, which had a significant positive impact on their learning.

The findings suggest that the involvement of the young participants 'being' the voice helped to create an authentic 'real-world' learning experience for the student nurses. Lombardi (2007) suggests that authentic learning is achieved in several ways, including focusing on real-world issues using role-play or case studies. The findings presented here support my contention that the simulation sessions offered the student nurses such a 'real-world' experience. Lombardi (2007) suggests that simulation can help students develop communication, leadership and collaboration skills and facilitates success in their field of practice. The development of communication and relational skills through this real-world learning experience is explored next.

6.4   Learning to build relationships

Developing and maintaining an effective relationship (relational skills) with a young person is essential in the delivery of quality care. Some of the young participants and student nurses explained how they had managed this during the simulation sessions:

> "*The other girl* [student nurse] *was more involved with the patient, speaking to her and making sure she was okay*" (Sarah)

> "*We asked about what year they were in at school, I think she said she was year 11, so we were 'oh are you doing your GCSEs', so talking about stuff like that*" (Nicola)

> "*I asked her about what she was doing in school and she answered back straight away, didn't she?…She was studying to be a police officer or something*" (Mandy)

> "[Debriefing]*…it was really good the way that you just kept the conversation going with her, so she was not thinking about her treatment or why she was in there…so you were taking her mind off everything else and just thinking about her*" (Louise)

The young participants and student participants revealed their insight into the role of nurses regarding the initiation of professional relationships. Rose et al. (2012) identified that the mechanism in the development of any therapeutic relationship involves the components of caring, honesty, trust, support, respect and empathy. The student nurses discussed how they were able to talk to the young person about social and school activities. This could have been due to the closeness in age between the student nurses and 'Elizabeth'. Shepherd's (2014a) phenomenological study reported that younger student nurses are in a unique position to provide emotional care for young people and promote a sense of normalcy [*sic*] owing to their age and stage of cognitive development. The student nurses seemed comfortable with this aspect of engaging with the young participants for the first time.

However, one student nurse reflected on the fact that they had not met the young participants much prior to being involved in the simulation sessions:

> "*I suppose that makes it more realistic though, doesn't it…that they don't know us…because patients don't know us, do they? So, every time we meet a new patient, we are working to build up a relationship with them every time*" (Andrea)

Here, she recognised that in practice she would not know patients prior to caring for them and that she would be required to establish an effective therapeutic relationship quickly with all patients. This appears to have been a valuable learning experience for this student participant, achieved in part through the involvement of the young participants.

It was apparent that the student participants began the development of their relationship with Elizabeth through normal, everyday and ordinary conversations. They did this despite the initial challenges that speaking to a manikin presented:

> "*I found that hard* [having a conversation with a manikin]. *Yes, because you don't have that eye contact. You can't pick up on the body language clues like you would do with a real person, so you're missing all that information, so you are essentially just talking to a voice*" (Andrea).

This comment emphasises the difficulties associated with using manikins in simulation and learning relational skills. Davis et al. (2017) express that an influencing factor with regard to a simulation and its perceived reality is the ability of the learner to conduct a conversation and interact with the 'patient'. However, the success of the simulation is based on the extent to which the learner engages in the scenario, as if interacting with a real person (Davis et al., 2017; Pike & O'Donnell, 2010). A lack of non-verbal communication cues is a significant drawback and can affect the learner's ability to interact with the manikin. This presents a significant barrier to the use and assessment of relational skills. This made me wonder if the simulation sessions could have been better facilitated if the young participants had taken on the role of Elizabeth. However, this too would have had its flaws. Portraying physiological changes and undertaking invasive procedures would have been limited. Manikins can be programmed to show acute deterioration and the associated changes in physiological signs, which is an important aspect of CYP nursing. They can also be programmed to produce an audible wheeze, an increased respiratory rate and low oxygen saturation. Such signs require the participants in a simulation session to make appropriate and clinically safe decisions. Being unable to replicate such factors with actors would have reduced the authentic reality experienced by the student participants. The learning outcomes of a simulation session determine

whether a simulated patient[11] or a manikin is used for the scenario. For instance, if the main learning outcomes are to manage conflict, develop a therapeutic relationship or break bad news, a simulated patient would be appropriate as no physiological changes are required. However, for a patient experiencing an exacerbation of asthma, a manikin is chosen in order that the physiological observations and changes are authentic. This highlighted to me the difficulties in simulation providing a truly authentic learning experience. However, the findings illustrated how the authenticity can be enhanced by having the voice provided by a young participant and by their involvement in writing the scenario.

6.5   Learning from difficult situations

The student nurses were undertaking a module that was focused on decision-making in practice. I wanted the student nurses to have to make decisions autonomously and to be challenged slightly. In the workshop I asked the young participants to think about the characterisation of 'Elizabeth'. When designing the scenario, the young participants talked about this and agreed that 'Elizabeth' should be asking numerous questions and have a challenging attitude towards the student nurses. One of the young participants told me how she felt about this:

> "*I was nervous…I really didn't know what to say. But by the time I got to the third one, I knew how the scenario was flowing and I knew what to say*" (Heather)

Some of the student nurses told me how they felt initially about talking to the young participant providing the voice of the manikin:

> "*I was scared of what the manikin was going to say because you never know what to expect a patient to say, especially a young patient as well…they have their own thoughts…if they don't want you to do something, they'll tell you…it just scares me a little bit…they might like knock your confidence…if you do something wrong*" (Sandra)

This insight reflects her knowledge on what could happen in practice, and, notably, she referred to the manikin as a 'young patient'. Other student participants revealed

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[11] A simulated patient is an actor (trained or non-trained) who plays the role of the patient.

how they had found the conversation with 'Elizabeth' quite difficult, yet they perceived this to be a good learning experience:

> "*I thought it was challenging, especially when she said, 'I want to go home', and then when her oxygen levels started coming up…having to explain, 'Well, no…you still can't go home yet'. And she said, 'I'll be able to go home in an hour, won't I?' And I was like 'Well, maybe not'. And it was really challenging…it was a good learning curve*" (Claire)

> "*She could come across as challenging because she was constantly asking the same question, so that was testing people's patience*…[saying] *'oh I feel all right now, I can go home' and not actually understanding that they still need to be reviewed…It was realistic*" (Jackie)

Although they found the conversation with 'Elizabeth' challenging, they deemed the learning from this to be of benefit. They had been required to manage a difficult conversation without the support of a mentor. This too augmented the authentic reality of the learning experience, as the student nurses recognised that such situations could occur in practice. Many of them concurred that the sessions had provided a realistic experience, and they noted the importance of listening to Elizabeth's point of view:

> "*I found it really realistic because they* [young people] *do ask questions…when you're there, and you're in practice*" (Claire)

> "*The actual dialogue on everything of it was really realistic. It was questions that a teenager would ask you, and it was as awkward as a teenager*" (Florence)

> "*I think it's better because some of the things she was saying like 'watch my hair', it's stuff that you hear the teenagers say, 'watch this, don't do this', and so it's better because you are getting it from a younger person's point of view and that's who you are going to be treating, so that's who you should be getting the point of view from*" (Heidi)

It seems that asking the young participants to take on the role of Elizabeth provided the student participants with an augmented authentic and real experience that felt natural. Overall, this had enhanced their learning experience.

The student nurses also talked about how they felt about communicating with 'Elizabeth' when interventions were required:

> "*She was like 'what's a nebuliser?'…right, how am I going to explain this to a teenager? Can't even remember what I said, opens your lungs or something, she said, 'they're already open'. I said, 'well they're not open enough'…*" (Nicola)

> "*I remember the doll* [manikin] *asking 'Oh, what do SATS mean?' And I thought 'Oh my god, do I have to give a textbook definition? Does it have to be child-friendly? Do I have to do that?'…*" (Sajeeda)

They were uncertain about explaining some of the clinical interventions required and questioned whether they should provide a technical or age-appropriate definition. In this situation the student nurses were provided with a learning experience that made them consider their communication skills, more specifically with a young person. I hadn't previously considered that this would present a challenge for the student nurses. Prior to undertaking this research, I would encourage student nurses to interact with a manikin as they would with a young person they were caring for in practice. However, it appears from these accounts that they were unsure about some aspects of the conversation and questioned their ability to communicate with a young person. This was highlighted through their discussion regarding 'Elizabeth's' relationship with her boyfriend, a relationship of which her father disapproved:

> "*You see I found that really difficult…because she says, 'Oh, my boyfriend is going to come in', I was unsure on what you're meant to say. Are you meant to say, 'Oh yes, that's fine' or are you meant to say, 'Oh, you have to speak to your parents'? Whose decision is it to say whether their boyfriend can come in? Is it our decision or is it the parents' or...? So, I found that hard, because I've never...that's never come across me in practice*" (Paula)

Here, the issue of allowing access to the boyfriend emerged. The student nurses were able to relate this to practice and questioned their ability to answer Elizabeth's

questions appropriately. This provided a valuable learning experience for the student nurses, and they reflected on how they should respond. They had felt uncertain about how to respond, and there were other occasions when the student nurses questioned their practice.

As the simulation session developed, one of the student nurses seemed comfortable in approaching the subject of health promotion with the young person and explained the conversation that they had:

> "*Well are you* [the young person] *aware of being in a car, passive smoking and things like that…and she said, 'oh well it wasn't me', and I was 'well it can still impact on you'. You've got to be wary of saying things like that sometimes to teenagers, especially when you are in hospital, because some of them will go 'do one' kind of thing 'you're not my mum'…*" (Heidi)

Heidi was the only student nurse who felt able to approach this subject and recognised that approaching this subject could possibly incite a negative reaction. The young participant acting as the voice of Elizabeth referred to her advice in the debriefing:

> "[Debriefing]*…obviously it would probably annoy and embarrass a real Elizabeth, but I thought it was good to get across that I should not really be smoking, or I should not really be near people smoking, that was a good idea*" (Heather)

Heather displayed insight into how 'Elizabeth' might have reacted negatively to the advice provided, although she recognised herself that this advice is necessary. However, although Julie was tentative about providing the advice, it is noteworthy that she was able to find an opportunity to have this conversation, as it is not always appropriate to address health promotion issues in the emergency department. The assessment and management of a person's condition is the priority, and once their condition is stabilised such issues can be discussed. In turn, developing a therapeutic relationship can be challenging if engaging in difficult or sensitive topics. This illustrated the complexities and challenges that student nurses face when learning how to care for children and young people.

6.6   Summary of chapter

To summarise, it is evident that the student nurses, lecturers and young participants described the scenario, conversations and interactions as authentic. They perceived the simulation scenario to be realistic, despite the challenging nature of some of the conversations and the situation that was being enacted. From these findings, I contend that the involvement of the young participants as social actors in designing the scenario and providing the voice of the manikin enhanced the authenticity of the simulation sessions. In turn, the student nurses and young participants were more able to 'suspend disbelief' whilst engaging in the scenario. However, some of the student nurses identified that the authenticity of the scenario was compromised owing to the inanimate nature of the manikin. Although a young participant provided the voice, the lack of body language and facial expressions and the inability to assess skin colour had an impact on their experience of fully immersing themselves in the scenario. This is a finding that has been reported elsewhere in the literature. As noted by Pike and O'Donnell (2010), student nurses are required to perceive a simulation as authentic if they are to learn and be engaged in the scenario. I propose that without the young participants' involvement the simulation sessions would have been less authentic and the student nurses would have received a less meaningful learning experience.

Chapter 7

Findings (3)   Uncertainty

7.1   Introduction

The previous two chapters (5 and 6) focused on the concepts of meaningful involvement and enhancing the authentic reality of simulation, notably through the involvement of young participants. In this chapter, I present and interpret the findings that relate to how the student nurses felt uncertain and apprehensive about the involvement of young participants, which had an impact on their capacity to have a psychologically safe learning experience. Ganley and Linnard-Palmer (2012) suggest that a psychological safe learning experience as being able to perform without the fear of consequences to self-image, career or social standing. Although there is some evidence to support what constitutes a safe learning environment in simulation (Fey, Scrandis, Daniels & Haut, 2014; Henricksen, Altenburg & Reeder, 2017; Rudolph, Raemer & Simon, 2014; Turner & Harder, 2018), I could find nothing published related to the impact and outcomes of involving young participants and the safety of the simulated learning environment. The findings presented in this chapter contend that the involvement of the young participants added a dimension of uncertainty for the student nurses, which may have had an impact on a psychologically safe learning experience. Whereas their uncertainty was fuelled by different factors, it was evident immediately before, during and after an HFS session Here, uncertainty was related to the themes *of unfamiliarity, being prepared, being watched, being assessed and the shifting relationship* between the student nurses and young participants.

7.2   Unfamiliarity

In addition to adequate pre-learning preparation, being familiar with the simulated environment is known to promote a psychologically safe learning environment (Turner & Harder, 2018). It is worth noting here that the student participants in this study were members of a cohort of students that had experienced minimal engagement with HFS. For most, it was their first experience of interacting with the manikins. This was due in part to the lack of appropriate simulation facilities and fewer opportunities to embed simulation into an existing curriculum. This led to the

student nurses feeling apprehensive about the simulated environment and the function of the manikins and thus was a facet of uncertainty for them. Feelings of apprehension were identified by the student nurses before, during and after an HFS session. One student nurse expressed how she felt petrified before she went into an HFS session:

> "*I find that I'm not very confident in terms of doing anything in front of people anyway, so for me going in there, because I'd not…obviously we've not had much exposure to the models and things, I was petrified of going in because…it* [the manikin] *could do anything, I don't know what it is* [the manikin] *going to do, what do I do if it reacts in a certain way, the blood pressure goes up*" (Heidi)

There seemed to be a link between previous exposure to HFS and how they felt during this session. Heidi points to her lack of confidence and her perception that this was heightened because of her lack of familiarity with the manikins. It is known that lack of exposure to the HFS environment can increase nervousness during the simulation experience (Cato, 2013; Feingold, Calaluce & Kallen, 2004). Other student nurses added that although they had experienced some exposure to the simulated environment previously, it had been some time earlier:

> "*…it is a great environment to practise but when you haven't used it for ages you do feel apprehensive about going in there*" (Andrea)

> "[Debriefing]*…I think because we did not know where anything was when we went into the room, in the first instant, that kind of confuses you. You have got a new patient in a new setting and you don't know where anything is, it is a bit hard*" (Maya)

> "*I think a big fear of some of us was that we haven't had much use of the high-fidelity labs, so I think we maybe had half a day or maybe less than that before, and I think because of that we weren't very confident using those models*" (Ameera)

> "*It's always going to be daunting, isn't it, people watching you, but I think it would have been a little bit less daunting had we have used them* [the manikins] *more recently*" (Andrea)

Some also understood that their exposure would help with future learning in the simulated environment:

> "*But if we had…another simulation…in the third year, I'd feel a lot more comfortable about doing it*" (Julie)

Here, some of the student nurses appeared to feel unsure about the environment as there had been a significant time lapse between their previous and current encounters with HFS. I had anticipated and tried to alleviate this fear by arranging an orientation to the environment, although this was relatively brief, lasting for around 30 minutes. The implications of this are further considered critically in the next chapter; for now, it is worth noting that this had made the student nurses more uncertain about what would happen during the simulation sessions. In keeping with Felton et al.'s (2013) pilot study, the student nurses were relatively unfamiliar with simulation, and this appeared to make them feel uncomfortable. That said, at some point students are required to participate in simulation for the first time, and these feelings are likely to be present if they are unfamiliar with this pedagogical approach. What is not known is whether the presence of the young participants added to these negative feelings, which could have had an impact on their ability to have a safe learning experience.

That said, some of the student nurses reported feeling more comfortable as the experience unfolded. This was most evident for one of the student nurses, who had to attend a session for a second time. This came about as there was an odd number of students on one of the days. I had planned for there to be an even number of students so that they could all work in pairs; however, one student was unwell on the day of the simulation. Another student volunteered to participate for a second time and explained what impact this had had on her experience:

> "*The second time I was absolutely fine. Because like you said, it's not scripted…so the young person was still coming out with things that were different. But the second time, I felt a bit like a mentor for Jackie, because she hadn't been in before, so I knew what was coming and she didn't, and plus she's not really had much ward experience, so she was really, really anxious, so I felt more as a support for Jackie than people watching me, if that makes sense. But I definitely did feel less anxious the second time. I think if I had*

only done it the once, I would have gone home feeling really…doubting myself personally as a professional, but because I did it the second time, I felt really proud of myself when I went home, so I think it completely flips it when you've done it a few times" (Paula)

She perceived benefits from repeating the session in terms of increasing her confidence, lessening anxiety and supporting another student. As she did report feeling content with her performance following the repeated session, repeating the session not only reduced her anxiety but also had positive benefits. This finding is in keeping with the notion of deliberate practice (Ericsson, 2006, 2008), whereby the simulation scenario is repeated until the learner feels that they have mastered what was required of them. Similar findings were reported by Teixeira et al. (2015), who reported that some students remained nervous after the session had ended and would be contemplating their actions when they had returned home. Although student nurse Jackie did not express concerns to this extent, this was something that I had never considered before. This made me reflect on how other student nurses feel after they have participated in their first simulation and whether there would be a way to ease such anxieties. In addition, although Paula did not relate this specifically to the involvement of the young participants, perhaps a more familiar relationship with them might have eased some of the student nurses' unease. However, the students repeatedly linked being familiar with HFS with a more positive experience:

"*Yeah…I felt more at ease with going in because I already had been with a simulation, I'd been involved with a little simulation anyway, so it wasn't as scary going in with…the manikin*" (Sandra)

It is apparent from the accounts of some of the student nurses that increased exposure and familiarity with simulation reduced their unease and fear about the sessions.

It is possible that exposure to a first HFS session is analogous to a first clinical placement. Some authors have identified that feeling anxious before a first clinical placement is not unusual (Chesser-Smyth, 2005; Sun et al., 2015). Previously, Kleehammer, Hart and Keck (1990) stated the environment can be predictable or challenging and students may feel overwhelmed. However, as Chesser-Smyth

(2005) reported, student nurses often felt anxious on the first day of their initial clinical placement but settled in once they were familiar with the staff and environment, with negative feelings diminishing.

The arguments regarding the importance of familiarity with HFS are strengthened by the findings reported here, as those who had more experience with simulation appeared more at ease about their participation. Regardless, in addition to the notion that familiarity with simulation diminishes unease, some of the student nurses highlighted other components that enabled them to feel more comfortable with the situation:

> "*We felt more at ease because we were with Sam* (lecturer) *as well. And we know Sam*" (Sandra)

> "*Well, I was like, I'm not sure how to do this, but Sam is my personal tutor, so I know her really well. And so, it was like I felt like more at ease…I've not been on a ward for ages so…I don't think I know how to do it, but she was helpful and it was fine*" (Claire)

It appears that the student nurses felt much more reassured when an HFS session was facilitated by someone they knew. One of the students identified that this was a comfort, as they had not had a ward experience for some time. This made me think also that before starting a simulation session it would be useful to find out what clinical experiences the student nurses had been assigned and how much support they might need from the facilitator. It is well established that in simulation it is important that the student nurses have a supportive facilitator who they feel they can approach if they need help or are uncertain about any part of the scenario. Ganley and Linnard-Palmer (2012) and Turner and Harder (2018) found that student nurses' anxiety was increased if the facilitator/lecturer was perceived as unsupportive or intimidating. On a different day the simulation was facilitated by a lecturer who, although a member of the children's nursing teaching team, was relatively unknown to the student nurses. I had not anticipated how the choice of facilitator would make a difference for the student nurses, and this was an unexpected, yet important finding. However, I cannot be certain that student nurses who were not familiar with their facilitator were adversely affected, as they did not discuss this with me. That

said, the student nurses who did know their facilitator asserted that this helped them feel more at ease.

To summarise, being unfamiliar with the environment and having a lack of exposure to simulation contributed to the student nurses feeling uneasy about the HFS session. The student nurses reported that they had little exposure to and experience with simulation during their programme and this had contributed to their feelings of apprehension. That said, such feelings were mitigated for some student nurses. For one, the opportunity to repeat the scenario a second time and, for others, knowing the facilitator were implicated in this.

7.3   Being prepared

As noted previously, the student nurses felt apprehensive and uneasy about some aspects of the simulation sessions. In part, familiarity helped with this. However, there were other factors at play, specifically, in relation to what they needed to know from theoretical and practice perspectives. This concerned what they needed to do to prepare for an HFS session and how they should react during the session. One student nurse made specific reference to her technical skills:

> "*We knew it was asthma, so in relation to an emergency situation with an adolescent with regards to asthma…we didn't know if it* [taking a blood pressure] *would be Dinamap*® [electronic] *or whether it would be manual, so we looked into that, just in case*" (Claire)

Being uncertain about her ability to perform a manual blood pressure resulted in Claire and a peer deciding that they needed to prepare for this, and they revised how to conduct a manual blood pressure prior to the HFS session. I had not considered that this would be a concern for the student nurses, but with hindsight I should have acknowledged that in many areas of clinical practice it is customary to use Dinamaps®. This means that some of the student nurses may not have carried out a manual blood pressure since being taught this skill at the beginning of their programme. Therefore, I could have provided a revision session on this skill in preparation for the simulation session, and this might have eased their uncertainty about performing this procedure on the day. That said, this points to the student

nurses as adult learners and using their initiative to practise a skill that they might not have been able to practise for some time.

Some authors have suggested that preparation for a simulation session should ensure that the learners have received some prior instruction, either online or classroom-based, so that they have an idea of what they are going to experience (Davis et al., 2017; Hellaby, 2013). As Turner and Harder (2018) note, being prepared helps students to feel psychologically safe during their simulation sessions, and this is important in order for them to be able to perform without the fear of consequences (Ganley & Linnard-Palmer, 2012). Although the student nurses were aware that the HFS sessions would involve a young person with asthma, no further details were provided. That said, the psychological safety of the sessions was promoted through a number of methods. The sessions were aligned with the module that the student nurses were undertaking and were consistent with the module outcomes, which had a focus on acute illness. In turn, the student nurses had participated in a seminar session led by a paediatric asthma nurse specialist, and their summative assignment for the module focused on the care of a child with an acute exacerbation of asthma. Thus, the safety of the learning experience was enhanced, as the student nurses had been provided with appropriate learning resources and opportunities prior to undertaking the simulation sessions. That said, there may have been other factors at play that hindered feeling safe in the sessions. As noted earlier, the student nurses had been informed that the simulation sessions would involve a young person with asthma. One of the student nurses commented on this:

> "*I was glad we knew it was about asthma because…I have dealt with these situations before in practice, so I felt more comfortable. I think if I didn't know what it was I would have been thinking about it could be this, it could be that*" (Julie)

Of note here is the fact that Julie appeared more confident with the session owing to her practice experience of encountering a person with asthma. For her, this preparatory information appeared to alleviate some concerns about what the simulation session would entail. Despite this, some of the other student participants

described how they felt before the simulation session; for many, this peaked immediately before they entered the simulation suite:

"[I felt] *sick*" (Claire)

"*She* [Claire] *was having palpitations*" (Sandra)

These adverse physiological symptoms are not uncommon whilst participating in an HFS session. Similar findings were reported in an integrative review of 11 studies, which found that physiological changes were present in many learners whilst they were participating in a simulation (Al-Ghareeb, Cooper & McKenna, 2017). More specifically, an increased heart rate was noted as a common physiological change. However, the findings reported relate to the learners' physiological symptoms during the simulation sessions, with no reference to how they had reacted prior to participating. Another student described how she felt immediately after the session:

"*As soon as I walked out* [of the simulation room] *I wanted to fall to the floor because I was just shaking*" (Heidi)

This finding was of concern. The purpose of simulation, as with any learning experience, is to promote a positive learning outcome rather than stimulate negative physiological symptoms. Reports of such symptoms challenge the notion of learning in a safe environment, especially as my intention was to adequately prepare the students for the sessions. However, although unexpected, this is not an uncommon finding and was reported by Garrow (2014), who found that student nurses felt anxious during simulation. Although the student nurses did not use the terms anxiety or stress, such symptoms are signs of anxiety; for example, an increased heart rate (British Psychological Association, 2018). It is also established that simulation can be an anxiety-provoking experience (Cantrell, Meyer & Mosack, 2017; Shearer, 2016); what is less clear is the extent to which the presence of the young participants was implicated in this. I had not previously considered that the involvement of the young participants would have such an impact on the student nurses; nor I had considered strategies to alleviate this.

As discussed, it became evident that the student nurses felt uncertain about what they would need to know before they participated in an HFS session; however, it was clear that they had similar feelings during the session:

> "*I was very scared of the younger people behind the wall judging me because I'm not very confident in what I know, so I was doubting myself…I don't know enough, I should know this, I should know that…I was scared that if I didn't pick up on a sign or a signal to do something that they'd be like 'oh she's not very good'…I'm going to be judged, I know obviously she* [the young person] *is there to help us learn…but I think having people who aren't from the university and are outside…they are going to expect us to know all these things because we are training to be nurses and I thought, I don't*" (Heidi)

Here, it seems Heidi had made a connection between being judged by the young participants and her perceived lack of confidence in her knowledge. She alludes to feeling pressure, which came from the expectation that she would be judged by the young participants, despite knowing that the young participants were there to help her to learn. Similar findings were reported by Cantrell et al. (2017), who found that students experience moderate or high levels of stress associated with simulation, yet they confirm that simulation is a valuable learning tool. Whereas some of the student nurses expressed uncertainty about their level of knowledge, others were questioning their communication skills:

> "*…I haven't done much around asthma apart from the assessment that we did, and she* [Elizabeth] *said…'what's a nebuliser?' and I thought…right, how am I going to explain this to a teenager?*" (Nicola)

Here, it appears that Nicola was unsure about how to communicate with Elizabeth. However, I found it interesting that Sajeeda talks about this in the context of a 'doll'. I wondered if she was unable to suspend disbelief and that communicating with a doll was difficult for her. In hindsight, I could have explored this further with her during the interview.

In addition, although I had agreed with the young participants that they should challenge the student nurses, the student nurses had not been told about this. Their comments indicated that uncertainty was again implicated in them feeling concerned when undertaking the simulation sessions. As noted in Chapter 1, there is an assumption that simulation sessions provide a safe and supportive learning environment (for examples, please see McCaughey & Traynor, 2010; Rush et al., 2010; Shearer, 2016). However, this is not perhaps how student nurses perceive the

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experience. Garrow (2014) and Ganley and Linnard-Palmer (2012) reported that students may not feel safe during simulation sessions as they worry about being embarrassed or humiliated if they do something wrong. Having the young participants present during this simulation session appeared to add to such worry. Not only did this arise prior to the session, it was also fuelled by concerns regarding appropriate responses to a young person's questions. Nonetheless, the simulation session had offered a unique learning experience, as it provided the student nurses with an opportunity to practise their communication and interpersonal skills with a young person in a simulated environment. This learning opportunity was reflected in the learning outcomes for the session, one being 'to communicate effectively with the young person, provide introductions and demonstrate sound interpersonal skills' (for a full outline of the intended learning outcomes, please see Appendix 12).

That said, one student nurse identified that she was not given the opportunity to demonstrate her sound communication skills, as noted:

> "*I was thinking people are watching me do this…I'm quite a talkative person so I would say a lot, whereas I felt that I was a bit nervous in the simulation so I didn't say much, and also because Belinda was talking loads I didn't need to, so in that way I felt like people were going to judge me like an incompetent, quiet, not chatty, not very personal person*" (Ameera)

Here, the Ameera's apprehension appeared to be exacerbated by her working with another student who was more talkative. As a result, she felt uncertain about how the young participants would perceive her ability to communicate with 'Elizabeth', and, as a result, she felt like she may have been judged as incompetent. On reflection, I find it concerning that she perceived she would be judged in this way; more specifically, that she felt incompetent and could be considered as "not very personal". For Ameera, the notion of simulation as a safe learning experience did not seem to be the case. I knew it was possible that being observed by the young participants could have detrimental effects, hence the need for the research. However, in turn, it is noted that in this HFS session the student nurses were working in pairs, and perhaps this hindered the ability of some students to impress. At this stage of their training, the student nurses would be likely to be working on their own

in practice, with their mentor to supervise as required. In the future, this is something that I need to consider when involving young participants.

As noted in Chapter 4, the young participants were involved in the planning, facilitation and debriefing of the simulation sessions. However, three of the student nurses expressed some uncertainty regarding their understanding of why the young participants had been involved:

> "*No…I didn't understand why the young people had to be there*" (Sajeeda)

> "*I thought they maybe wanted a few days off college*" (Bridgit)

> "*I forgot the reason* [they were there]" (Belinda)

However, the information was included on the participant information sheets (see Appendix 2), and I had delivered a face-to-face session about the research study to the student nurses. This had occurred several weeks before the HFS sessions, and it is possible that a short recap immediately before the sessions might have helped with this. However, some of the other student nurses appeared to have a better understanding of the role of the young participants before and after the simulation session:

> "*To gain their feedback really…on how they perceive the care given*" (Andrea)

> "*That they were there to set…the scenario, so it wasn't like you'd set it, it was an actual adolescent, so it was more realistic*" (Claire)

> "*To get feedback as well of what we are like and…what they want*" (Mandy)

> "*To get their perception on what it's like to be a patient, I suppose, and they were looking at how we were with the patient to see if that's good or not in their opinion as young people*" (Nicola)

They recognised that the young participants contributed to writing the scenario and delivering feedback from the perspective of a young person. The young participants provided the student nurses with feedback on the care they delivered and observed them in their roles as student nurses. These students recognised the significance of the young participants' contributions. One student nurse provided a sophisticated insight into the reasons why the young participants were involved and recognised

that it was about listening to 'what they want'. Still, the involvement of the young participants was implicated in the students feeling uncertain about what was expected.

To summarise, the student nurses expressed uncertainty, which related to their perceptions about their preparation and what they needed to know before and during the simulation session. For some, this resulted in them experiencing feelings that are associated with stress-related situations. Moreover, before they participated in the simulation session, it seemed that the student nurses had not all fully appreciated the value of the young participants' involvement.

7.4 Being watched

The HFS sessions were streamed live to another classroom so that the young participants could observe the sessions and contribute to the debriefings in a meaningful way. Again, the notion of being watched was a concern for the student nurses before and after the simulation sessions. As for the student nurses, they were uncertain about being watched and did not feel comfortable being watched by the young participants. The young participants observed the simulation sessions from a different room, and the student nurses discussed how this made them feel prior to participating in the simulation sessions:

> "*Seeing all the young people waiting in that room watching it on the big screen, I suddenly thought 'oh my goodness this is terrifying'…it was almost like before they draw the curtain back on the stage…*" (Andrea)

> "*I was okay with knowing they were watching until I actually saw them all in the room. When they opened the door and they were like 'here's all the young people in here who are going to watch you on this big screen' and I just thought 'oh my goodness me'. I felt like throughout the entire process I was very, very tense. I didn't forget they were watching. Maybe if we were in there for a bit longer possibly, you'd start forgetting that people were watching you, but it was on my mind a lot that there were people in that room watching on a big screen*" (Andrea)

> "*When we went in and walked past and we saw them, we were like…*[gasps]" (Julie)

This had had an impact on Andrea's experience, as she was unable to forget that she was being observed by young participants throughout the session. Whereas it has been argued that the involvement of the young participants created a more authentic reality, their involvement also appeared as a barrier to the provision of a more authentic experience. In turn, this may have affected the ability of this student nurse to have a safe learning experience. Although the student nurses were prepared in advance for this element of the simulation, some did not react well when they walked past the debriefing room and saw the young people watching the 'big screen'. One student nurse talked about "waiting for the curtains to be drawn back on stage", a feeling that may be felt prior to performing in the theatre. Similar findings concerning the feeling of performing on stage have been reported elsewhere in the literature (Beischel, 2013; Garrow, 2014; Nielson & Harder, 2013). I had not considered that the student nurses would feel so uncertain about being watched and moreover have such adverse feelings about the young participants watching them. That said, it is known that being observed in simulation increases the level of anxiety for students (Cordeau, 2010; Paige & Morin, 2013; Shearer, 2016). However, what has not been reported elsewhere is the added dimension of young participants as observers, exacerbating feelings of uncertainty and apprehension in learners.

Thus, from the accounts of the student nurses, it appeared that the involvement of the young participants added to feelings of discomfort. I had not anticipated how the student nurses would react when they saw the young participants sitting in the room. The idea that the young participants were watching so that they could provide feedback on the students' performance seemed to be overshadowed by the notion of surveillance. At this point, the student nurses were not able to understand what the benefits to them would be with regard to the observations of the young participants and how these could create a more authentic reality for them:

"*Do I feel ready enough to get someone to watch me in what I am doing?*" (Paula)

"*I think being watched…because you're being watched, I think it's a lot of pressure, and like you're going to do something wrong*" (Julie)

> "[Debriefing]*…I panicked straight away and I don't feel like it has reflected how I am really in practice…It is because I know people are watching me*" (Sajeeda)

Here, whereas Paula expressed uncertainty about whether she wanted to be observed by the young participants, Julie and Sajeeda identified how they were concerned about doing something wrong whilst being watched and that it was not representative of how they would act in practice. Similar findings were reported by Cordeau (2010) and de Souza Teixeira et al. (2014), who found that reasons for increased anxiety levels included being watched by peers or faculty. I started to consider why the student nurses felt so nervous in this situation. In practice, they are constantly being observed by their mentors, practice staff and children and families. However, perhaps in practice student nurses are able to disregard feelings of being watched by children and young people, because feedback and assessments of competence are delivered by their mentors rather than directly from patients. In addition, perhaps in practice the pressure of a busy ward environment overshadows the idea of being watched by children, young people and their families. Andrews et al. (2006) suggested that if staff are overworked or stressed they may dedicate less time for student nurses. In the HFS sessions there was one patient in the room, and perhaps this did not represent a real ward environment as there was no background noise or activity.

However, this insight was not wholly representative of the experiences of all the student nurses. Some of the students reported that they had forgotten that they were being watched and that the simulation session was being streamed live:

> "*They're watching me…but then once I got in there, I felt more relaxed*" (Sandra)

Although initially concerned about the young participants watching her, Sandra felt more comfortable once she was immersed in the HFS session. Perhaps this was due to the increased authentic reality that the young participants brought to the scenario, which enabled her to feel more relaxed and become immersed in the simulation session. This is in keeping with the concept of being able to suspend disbelief and entering into the fictional contract (Dieckmann, 2007; Muckler, 2017),

with learners believing they are operating in a real clinical environment. For this to be possible, the learners need to ignore observers or dismiss them from their minds.

However, the young participants were also aware about how the student nurses might feel about being watched:

"*I think we were nervous as well, because we knew they were nervous to actually do it in front of us watching. But when they came back into the room and we'd given them the feedback…they all took it on board and listened and took it well*" (Lexy)

"*It must've been hard for them to perform in front of* [us]*, knowing there was other people watching them and going to give them feedback on the end*" (Holly)

Here, Lexy and Holly demonstrate a sophisticated insight into how the student nurses were feeling during the session and how they felt about receiving their feedback. This was a positive outcome for the young participants that I had not expected. This resonates with and supports the concept of meaningful involvement and that the young people felt valued through making a difference to the student nurses, as discussed in Chapter 5.

In addition to the student nurses and young participants recognising that being watched by others was unsettling, the lecturers too discussed how they thought the student nurses might react to being watched by the young participants:

"*I think that from my experience students do generally feel there's almost a higher anxiety factor when they are streaming…I didn't sense that they were overly nervous to what I would expect. And when they were in they all seemed to get into the role, there didn't seem anyone who struggled to actually do it. So, to me, it seemed like a normal reaction in a normal simulation experience*" (Sam)

This lecturer was a regular facilitator of simulation and appeared to be cognisant of the possible feelings of anxiety that might be experienced. Her observations seemed to indicate that the involvement of the young participants did not increase the anxiety

of the student nurses and that, for her, they seemed to react in the same way as students usually do in a simulation. As one student nurse highlighted:

"*I definitely spent time in the room feeling judged…whilst I was in* [the simulation] *I was thinking there's people watching me, there's lecturers watching me, there's young people watching me, etc.*" (Ameera)

Two of the other lecturers also discussed the issue of being watched by other people:

"*I think as students involved in simulation, there is generally an element of someone observing them, and they're aware of that*" (Danny)

"*Although some of them say they're concerned about it being filmed…I actually think the groups that I worked with, I think once they started…they forget about the camera as well, because it is not that intrusive, and then they get involved and wrapped up in what they're doing, so I don't think they did any more than normal actually*" (Chris)

It seems that there was a common understanding that as the student nurses became immersed in the simulation the more able they were to disregard the notion of the session being streamed. It is possible that immersion in the session was enhanced by the presence of the young participants, which in turn enabled a more authentic reality. However, it is noted that the lecturers appeared to make presumptions that all simulations provoke feelings of uncertainty and apprehension. I had not contemplated this in the past, but this made me think about how these could be minimised to ensure that students are learning in a psychologically safe environment.

In summary, some of the student nurses discussed how they felt about 'being watched', and this created feelings of uncertainty for them. They expressed how this had an impact on how they performed during the simulation; they referred to how nervous they were before they went into the simulation and that their anxiety levels or apprehensions were heightened because the young participants were watching them. In turn, having the young participants almost 'hidden away' and observing from a different room seemed to exacerbate the situation. Nonetheless, the student nurses, on reflection, commented that although being observed during the simulation made them feel uncomfortable, they had still learned from the experience. The

lecturers concurred that the issue of live streaming was anxiety-provoking; however, they identified that this was a normal reaction to participating in a simulation. Thus, there is no doubt that the notion of being watched was perceived as a drawback for the student nurses. Moreover, I had introduced another dimension into the simulation through the involvement of young people. As noted in Chapter 6, although the young participants had enabled a more authentic reality for the student nurses, I had not considered how this might have had a detrimental effect on their learning. It seems that finding a balance between enhancing authentic reality and providing a psychologically safe learning environment is paramount and requires consideration for future work.

7.5   Being assessed

Some of the student nurses appeared to be uncertain about whether they were being assessed during the simulation. Despite attempts to reassure the students that this was not a formative or summative assessment prior to the session taking place, they expressed feeling nervous because they thought they were being assessed. Many of the student nurses felt this way:

> "*Honestly it felt like it was being assessed. I know it weren't, but I get really nervous*" (Heidi)

> "*We knew what was coming, we knew who we were going to be meeting and what the assessment* [of the patient] *was going to be like and how we were being assessed*" (Florence)

> "*You talk about assessment? That's interesting*" (Researcher)

> "*Well, it wasn't an actual assessment, but we were being watched*" (Florence)

It is worth noting that they associated assessment with being watched. That said, the notion of being assessed may have been related to the development and use of the feedback tool the young participants had designed to note down their observations.

However, Paula provided a different perspective on the notion of being assessed:

> "*…we're not getting assessed…but we kind of are…even though it's not assessed, if we did something wrong…someone could pick up on it and tell us…*" (Paula)

The idea of making a mistake and this being noted was important here, as it could have implications. The young participant might notice this and report it back to her in the debriefing. This challenges the important notion of the learner being able to make mistakes without fear of the consequences (Rudolph et al., 2014; Shearer, 2016; Turner & Harder, 2018). For Paula, this challenged the concept of simulation as a psychologically safe learning experience.

Another student nurse provided a different view on the idea of being assessed:

> "*I guess it's sometimes more worrying, more scary, in a university environment when you feel like you are being assessed, but actually in practice you are being assessed all the time by your mentor anyway. So, it could be fairly reflective of being in practice*" (Ameera)

Ameera recognised that the HFS session was comparable to being in practice. Although her reasons were not clear, she stated that she felt more scared about being assessed in a university setting than in practice. However, she did appear to have a less negative stance about being assessed during the HFS session, which she understood as an ongoing process that was less structured and formal.

Another student offered a different perspective:

> "*Everything we do in university is assessed, so it was quite refreshing in a way to be part of something where…we are being assessed but it's not a formal assessment*" (Andrea)

For this student, it appeared to have been a positive experience, and, although she still referred to being assessed, this did not seem to have an impact on her ability to have a safe learning experience. All the student nurses expressed uncertainty about the notion of being assessed, and it is likely that this had an impact on how they performed during the session. For some, as noted earlier, this was manifested through a change in physiological symptoms. For student nurses, feeling like they are being assessed during a simulation is not uncommon and can augment feelings

of anxiety. Perhaps this is because the students are aware of having the facilitator, who is observing their practice for discussion in the debriefing, in the room, which could be perceived by the student nurses as an assessment or their actions being scrutinised. The debriefing process enables students to reflect on their own practice, but should poor practice or areas that require development be observed it is the role of the facilitator to ensure that those issues are addressed. However, the student nurses seemed concerned about the young participants 'assessing' them, and this was an added dimension for the student nurses, perhaps exacerbating this feeling of 'being assessed'.

In keeping with Turner and Harder (2018), preparation and a pre-briefing are paramount to ensure a psychologically safe learning environment. The role of the lecturer who welcomed the students before the start of the simulation was to provide this pre-briefing, reassure them, answer any queries and ensure that they knew that they were not being assessed. This lecturer provided some insight into the behaviour and reactions of some of the student nurses prior to commencing the simulation session:

> "*I think when they arrived they were really nervous. They weren't 100% sure of what to expect. But once I'd gone through with them what they could expect and what was going to happen they opened up and they started asking loads of questions so…about the simulation and what was going on. And I think that helped put them at ease a bit…They thought they were being assessed…by the rest of the team and it was all about them and all about their practice…So I did a lot of reassurance that that wasn't the case*" (Jerry)

Here, it is evident that Jerry had been supportive and helpful and tried to ease their uncertainty about the HFS session. However, it appeared that the student nurses did feel as though they were part of an assessment, and this had made them feel nervous and scared. That said, other research has indicated that being observed was reported to increase anxiety, irrespective of whether it was a summative or formative assessment (Beischel, 2013; Cordeau, 2010; Paige & Morin, 2015; de Souza Teixeira et al., 2014). Although this was not a formative assessment, the student nurses appeared to perceive it as such. Jerry also confirmed that the student nurses were nervous because they were uncertain about what was going to happen

in the simulation session. Some of the student nurses told me more about how Jerry had reassured them prior to the HFS session:

> "*Jerry was really, really lovely and speaking to us. And Jerry like reassured us*" (Julie)

> "*Yeah, Jerry was like, just remember it's not you getting assessed*" (Mandy)

From the accounts of the student nurses, it appears that Jerry had succeeded in reassuring the student nurses and made them feel slightly more at ease about the notion of being assessed. I did not consider how significant the role of Jerry would be prior to undertaking the simulation scenario and on reflection was grateful that he/she had facilitated this role.

Once the student nurses had undertaken the HFS session and had had time to reflect, one student nurse felt differently:

> "*I'd feel so much more at ease, yeah. I wouldn't feel…I think now going in, I wouldn't even feel like I was being assessed*" (Claire)

Here, Claire recognised that she felt more comfortable with simulation after participating this time. This brought me back to the concept of feeling uncertain about simulation and that with more exposure and experience these feelings could be negated. At this point, I also considered whether I could have done more with the student nurses to ease their nerves and reassure them that they were not being assessed by the young participants.

To summarise, although the student nurses had been informed that this was not an assessment many of them were still uncertain about whether they were being assessed. Perhaps this was because they were being directly observed by a lecturer (the facilitator) and the young participants. The findings suggest that student nurses would perhaps feel differently if they were able to undertake a simulation without the surveillance of lecturers, peers and, as in this case, young participants. However, the benefits of the young participants' involvement that are now known would not have materialised.

7.6   Shifting relationships

In Chapter 5, the concept of meaningful involvement identified the interface and some structural challenges that came to bear on the relationship between young people and adults in this study. For now, this has focused on the relationships between the young participants, curriculum leader and lecturers. In this concept of uncertainty, there was a theme that related to the relationship between the young participants and student nurses, specifically in reference to their age and academic status. Two of the student nurses exchanged thoughts about this:

> "*At first I was a bit worried…'oh there's going to be young people watching us and saying, this is what this should be like and we're looking for this and we're looking for that…it's a bit patronising isn't it?'…College students trying to judge what a student nurse should be like? But that's not what I felt like afterwards. At first, I* [thought]*…I don't know whether I'm going to like college students judging me as a student nurse*" (Florence)

> "*I know because we're not much older, are we?*" (Bridgit)

> "*Compared to college students. Because who was the oldest one…About 17? So, two years younger than us…that's what scared me…*" (Bridgit)

It seems that the student nurses felt disconcerted and uncertain about college students watching and 'judging' them. The student nurses initially described feeling 'patronised' about having young participants observing them and providing them with feedback. It was not until during the debriefings that the student nurses reflected on this and realised that the feedback was beneficial for their learning. Thus, as explored in Chapter 5, there may have been an initial feeling that there was an academic hierarchy between the young participants and student nurses. Despite their closeness in age, this difference was observed between the young participants and the student nurses. It is important to note that of the 15 student nurse who participated in the interviews, two were mature[12] student nurses, more specifically, over 25 years old. These two students made no reference to how they felt about the

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[12] A person is considered a mature student if they are over the age of 21 and didn't go to university after school or college.

difference in age. However, the other student participants and the young participants seemed cognisant of the closeness in age but separation by educational status:

> "*Because, especially me, I'm not a nurse, I'm only doing, I'm only in college and I need to tell someone who is in the third year of nursing who actually knows what they're doing that maybe you've missed this was a bit nerve-racking*" (Heather)

> "*It was nerve-racking because obviously you've never met them before, and you didn't know which way they would take it* [the feedback]. *But they all seemed like they really wanted to know the positives and negatives about their performance…obviously because they want to improve on it*" (Holly)

Of note is the term 'only' used by Holly, as it appeared that she felt nervous about giving feedback to the student nurses. This again highlighted the notion of a difference in status between the student nurses and young participants. This could also be attributed to the perceived difference in the knowledge and skills that the young participants had in comparison with the student nurses. For the young participants, to provide feedback to those who were more experienced presented them with a difficult situation. Whereas Heather expressed concern about providing feedback, Holly displayed an insight into the benefits that their feedback would bring for the student nurses. She identified that the student nurses would benefit from listening to the young people and this would have an impact on their performance and learning. Here, Holly was positioning herself with a higher status while recognising that the involvement of patients (young people) was significant for her learning. In keeping with the findings reported in Chapter 5, this is a further example of how there was a constant shifting in the positions of the young participants. In this context they perceived themselves in a lesser, subordinate position to the student nurses. The purpose of inviting the young people to participate was so that they could bring their expertise on young people's lives to the simulation sessions. At times, this may have been thwarted by a perceived status difference between the young participants and student nurses.

In summary, it appears that many of the student nurses identified that it was unsettling to be observed by people who were younger and less experienced than

them. In turn, the young participants also recognised that this could be a potential barrier in terms of how the student nurses might feel about being observed by them.

For me, the role of the young people was to provide feedback to the student nurses using the tool that they had devised. Therefore, the student nurses were correct, as the young people had to observe them in order to make judgements on their performance regardless of whether the feedback was positive or negative. However, the student nurses perceived this as a negative consequence, which at times made some of them feel uncomfortable.

7.7   Summary of chapter

Following interpretation of the data, it was evident that there were a number of uncertain components of the simulation sessions that had an impact on the learning of the student nurses. I contend that this was associated with the student nurses feeling uncertain about their knowledge and skills, unfamiliar with the environment, being watched, being assessed and the shifting relationships between the young participants and student nurses. However, it is not fully known whether these elements were heightened by the presence and involvement of the young participants, as there was no comparison. Although the involvement of the young participants enhanced the authentic reality of the simulation sessions and had positive outcomes for the young participants and student nurses, there were some drawbacks for the student nurses.

In simulation, it is essential that the students are learning in a psychologically safe environment (Turner & Harder, 2018; Warland, 2011). This includes having a supportive facilitator, adequate preparation and being able to make mistakes without the fear of consequences (Fey et al., 2014; Ganley & Linnard-Palmer, 2012; Nielsen & Harder, 2013; Turner & Harder, 2018). The benefits of simulation are well documented, but the negative effects or outcomes are afforded much less attention. If simulation is to be a safe learning experience for the student nurse, it is important that the facilitator understands what affects this experience and what might have an impact on their performance or reactions in the simulation sessions. I argue that this study provides an insight into such factors.

Chapter 8

Discussion

8.1   Introduction

In this section, I summarise and provide a critical discussion derived from the main findings of this study, drawing together the three concepts of meaningful involvement, creating a more authentic reality and uncertainty. As noted in Chapters 3 and 4, the young participants designed the scenario and feedback tool, provided the voice of the manikin, observed the student nurses and contributed to the debriefings. The significance of young people's agency in this study was prominent, and the involvement of young people in simulation has not been reported elsewhere in the literature. Because of their involvement, the student nurses experienced a more authentic reality during the HFS sessions and valued the contributions of the young participants. However, some uncertainties emerged, more specifically in relation to the unfamiliarity of the experience, being prepared, being watched, being assessed and the shifting relationships between the young participants and student nurses.

8.2   Meaningful involvement

In the review of the literature I reported that children and young people can make an important contribution to nurse education; however, there was no specific literature that reported on this in the case of simulation. In Chapter 5, I argue that for the young participants involvement in simulation was a meaningful experience. The theoretical framework underpinning this study was to ensure that the young participants were not passive but active agents, with the freedom, encouragement and ability to make a meaningful contribution to society (James & Prout, 1997). This, I propose, was achieved through the involvement of the young participants in simulation with students of CYP nursing and was demonstrated through finding, developing and sharing their voices. It emerged that I had privileged their position as young people, with their emic perspective playing a significant role within this study. More specifically, the young participants brought their subjective views of being a young person to the fore, which only they could succeed in doing. The accounts of the

young participants revealed that throughout the process they each felt valued and listened to and exercised their independence as young people.

Furthermore, when presenting the findings, I identified the various involvement activities that were undertaken with the young participants and I proposed that these strategies could help build their resilience. Such strategies are in keeping with the literature and have been applied within the findings (Chapter 4) (Daniel & Wassell, 2002; Grotberg, 1997; Newman, 2004). These commentators provide suggestions of activities, behaviours or strategies that can help build resilience, and these were evident through the involvement of the young participants in this study. In keeping with Daniel and Wassell (2002), the young participants were engaged in strategies that can build resilience. The most significant of these strategies included having strong mentors (the curriculum leader and me), having a positive school experience (involvement in the study as an extracurricular activity) and being able to make a difference to others (the student nurses).

There were, however, some unexpected findings that emerged during a conversation that I had with the curriculum leader after the simulation sessions had taken place, and this presented a challenge. As identified in Chapter 3, the curriculum leader had, without my knowledge, devised a strategy for selecting which college students she would put forward to participate in the study. As a result, these actions had limited my access to potential participants who were deemed unsuitable by the gatekeeper, which, as Punch (2002) identifies, may have prejudiced the data. Moreover, this conflicted with the notion of children's agency and the importance that all children and young people are listened to. In this study, the curriculum leader unintentionally asserted her position over the young participants, and, in keeping with James and James (2004), they remained subordinate to and regulated by an adult. Suppressing and denying the agency of some of the college students resulted in the omission of their perspectives and confirmed their dependence on adults (James & James, 2004). That said, even if I had known this at the time, I would have found it difficult to challenge the actions of Diane owing to the relationship I needed to sustain with her as gatekeeper of the study. As Morrow (1999) highlights, when undertaking research with children and young people it is paramount that the researcher builds a good rapport with the gatekeepers, who are often teachers. Therefore, despite the best intentions there may always be restrictions or constraints

on involving young participants in research. In turn, the multi-layered complexity of the relationships between adults and young participants has been brought into sharp focus by this study.

The concept of adults' positioning and power relations when undertaking research with children and young people is not new. Whereas some authors (McLaughlin, 2013; Richards & Schwartz, 2002) identify that there are commonly power differentials between researchers and participants, Duncan et al. (2009) recognise that this unequal relationship is amplified when undertaking research with young people. Participatory research with children and young people is discussed extensively in the literature, and issues of power are referred to in terms of ensuring that there is an equal power balance between researcher and participant or child as co-researcher (Fallon et al., 2012; Lambert, Glacken & McCarron, 2013). The young participants did not disclose or allude to any power issues between themselves and me, unlike the young participants in other studies (for example, Felton & Stickley, 2004; Rhodes & Nyawata, 2010), who did report power issues between service users and researchers. Rather, the young participants in this study reported that myself and the other facilitators had been supportive.

That said, in the debriefings some of the young participants were less vocal and provided relatively brief feedback to the student nurses. It was noted that the facilitators of the simulation sessions and debriefings were relatively unfamiliar to the young participants. Punch (2002) suggests that children and young people may not feel confident communicating with adults who are unknown to them, more so if they are in a one-to-one setting. Moreover, Hopkins (2010) discusses young people's vulnerability to the unequal power relationship in research, with young people often accustomed to having to please adults, and a possibility of them being scared by the adults' reaction. Therefore, it could be that the young participants in this study felt inhibited in the context of the debriefings, as the facilitators were required to guide the discussion. Punch (2002) maintains that children are used to adults dominating them and exerting their power and may not be accustomed to being treated with equity and parity. Although the young participants did not tell me that this was the case, in future work I would need to consider how the participants might react with adults unknown to them and consider strategies to manage the situation better. For me, it was essential that the young participants expressed their opinions without

being influenced or, worse still, dominated by adults. Although the young participants were not dominated by the adult facilitators, in some cases their brief delivery of verbal feedback pointed to a potential lack of confidence. Casey and Clark (2014) discussed the assessment of student nurses and the involvement of patients providing feedback in practice. It was suggested that patients must be sufficiently prepared and supported in the process of delivering effective feedback and that some may feel unclear about what they are required to make judgements on. In this study, I had mitigated such feelings by providing training on the delivery of feedback.

The findings illustrated that the feedback from the young participants was valued by the student nurses, more specifically in terms of it representing feedback from a young person's perspective. Involving service users in providing feedback to students in practice is relatively new, and there has been a recent increase in the literature reporting on this (Casey & Clark, 2014; Debyser, Grypdonck, Defloor & Verhaeghe, 2011; Muir & Laxton, 2012; Stacey, Stickley & Rush, 2012; Stickley et al., 2011). These studies focus on the contribution that service users make to the provision of feedback to students in clinical practice settings and mostly refer to the assessment of practice. However, some authors have explored the contribution that simulated patients can make to feedback to student nurses within a simulated environment (Bokken, Linssem, Scherpbier, van der Vleuten & Rethans, 2009; Edwards & McCormack, 2018; O'Hagan et al., 2013; Webster et al., 2012). To date, no literature has been found that discusses feedback provided by service users (adults, young people or children) when using a human patient simulator. Furthermore, the NMC (2018a) recognise the important contribution that service users and carers can make to the education and assessment of nursing students in relation to the provision of feedback. Archer (2010) recognises that feedback in healthcare education can be challenging for both the learner and the provider, as settings can be diverse. Therefore, if service users are involved in this process further challenges and potential difficulties could occur if it is not suitably planned and executed. However, the findings in this study go some way in demonstrating the transparent ways of working and how such difficulties can be avoided.

It was apparent from the findings that although most of the young participants seemed comfortable with delivering feedback, one participant (Melissa) felt nervous about providing honest feedback to the student nurses. She explained that she felt

nervous because the student nurses were older and 'way ahead' of her in terms of academic status. As Robinson and Kellet (2004) identify, what preserves the unequal power relation is based on the concept that superior knowledge belongs to the adult. In turn, Duncan et al. (2009) explain that if there is an indication that a young person has a lack of power they may not feel comfortable to ask questions or able to provide honest answers; this could be related to how Melissa felt during the debriefing. Others argue that children may also lie to adult researchers for various reasons, including saying what they consider is the right thing or what the researcher may wish to hear, or to forge a positive impression (Ennew, 1994; Gersh, 1996). However, in accordance with Punch (2002) it was important that I invested time in building up a good relationship with the young participants, which I did through working with them on various occasions prior to the day of the HFS session and conducting the interviews. As a result, I hoped that the debriefings and interviews would be conducted with integrity and honesty. This is supported by Ennew (1994), who suggested that evading or lying in research is less likely to occur if the researcher has developed a good rapport and trust with children. I believe that I had developed a good relationship with the young participants, evidenced through their ongoing commitment to the study, and this had also been confirmed by Diane (curriculum leader). It was apparent that they felt valued and their involvement had made a difference to the learning experience for the student nurses. The student nurses valued the feedback from the young participants and additionally indicated that their involvement created a more authentic reality in the simulation sessions.

8.3   Creating a more authentic reality

Following the involvement of the young participants, the lecturers and student nurses reported that their contributions enabled a more authentic reality during the HFS sessions. More specifically, this was in relation to enhancing the reality of the simulation scenario, being the voice of the manikin, learning to build relationships (through authentic conversations) and managing difficult (authentic) situations. The student nurses reported that the HFS sessions felt realistic, which led to a more authentic and meaningful learning experience for the student nurses.

In keeping with Crowley (2013), the experience of simulation is more meaningful when the participants immerse themselves in the scenario; to do this, the perceived

authenticity of the simulation is crucial. As noted in Chapters 5 and 6, to maximise authenticity, the ability to 'suspend disbelief' is salient when participating in a simulation session. Dieckmann et al. (2007) explains that simulation depends on the participants entering into a fictional contract. The ability to suspend disbelief in simulation relies on the learner being able to accept that the situation is real and believe that they are working in an actual clinical environment (Power et al., 2016; Rudolph et al., 2014). In this study, the student nurses identified that the situation felt 'real', and most of them appeared to be immersed in the fictional contract. This was in terms of the authenticity of the scenario and authentic conversations during the HFS sessions. More specifically, in the findings I reported that most of the student nurses were able to interact and communicate with the manikin (Elizabeth) as if she were a real patient. However, some of the student nurses found this aspect of the HFS session more difficult than others. In keeping with Wilford and Doyle (2006), learners need to interact with the simulator and communicate with the manikin as if engaging with a 'real' patient; otherwise, the suspension of disbelief will not be achieved. However, for some of the student nurses in this study this was difficult to achieve, and they attributed this to the absence of body language. That said, all the student nurses agreed that the context of the scenario was realistic, and this was due to the involvement of the young participants.

In Chapter 5, I identified the benefits that arose from the involvement of young participants in designing the scenario and the significance of providing a realistic context. It is clear that the authentic social history and context of the scenario enhanced the learning experience for the students. Holland et al. (2016) advocate that the credibility of a scenario is enhanced by using real incidents or events. Although Holland et al. (2016) relate this to the clinical aspects of the scenario (for example, a trauma or medical emergency), using a 'real' background and context for the scenario can also enhance authenticity. In addition, it is suggested that using a collaborative approach to the design and facilitation of a simulation course is paramount (Holland et al., 2016), thus supporting the concept of co-production of the simulation scenario and in keeping with the notion of agency. Furthermore, these authors explain that educationalists, clinicians, simulator faculty and college tutors should all be involved in this process; however, it is notable that no service user involvement was referred to. Therefore, this study adds to the body of knowledge in

relation to the important and meaningful contribution young people can bring to providing a realistic context for simulation scenarios.

In this study, the young participants had designed the simulation scenario and the debriefing tool. In keeping with the co-production guidance from the Wheel of Participation (OCC, 2012), the young participants had constructed the ideas and only referred to me for support, advice and expertise. Thus, I contend that involving the young participants to this extent enabled a more authentic and realistic scenario. This was a significant finding; as Harder (2010) suggests, a well-constructed and realistic contextual environment is paramount in the facilitation of students' learning. Furthermore, as Rhodes (2013) highlights, there is a difference between a lecturer using a scenario from professional practice and a 'real' situation that can be described or written by a service user. Although Wanless and Aldridge (2012) claim that involving service users as 'consultants' in the design of scenarios is becoming more common, there is no known research that reports on the involvement of service users (of any age) in the scenario design stages of a simulation. I propose that this study is the first to report on such involvement.

In Rhodes's (2013) study of involving a parent in the classroom, the key theme of authenticity was identified, highlighting that service users are a significant adjunct to learning. However, as identified in Chapter 2, this was with regard to learning in the classroom as opposed to a simulated environment, which provides a different context for learning. Service users can help students learn by presenting a 'real' context, which cannot be learned through didactic teaching. Rhodes (2013) suggests that authenticity is a key strength of service user involvement, resulting in memorable and meaningful learning. Similar findings were reported by Mackay and Millar (2011) in social work undergraduate education, stating that it was the input of service users and carers that made a session feel 'real'. Felton and Stickley (2004) explored the impact of service user involvement in mental health undergraduate nursing, reporting that the lecturers stated that the involvement of service users was valuable for the students and offered a perspective that professionals would not be able to provide. However, there is no known research that reports on the contribution that young participants make to students' learning. In this work, I realised the significance of the emic perspective that the young participants had brought to the simulation sessions.

Irrefutably, their insight, knowledge and experience of being a young person were valuable to the learning experience of the student nurses.

Another significant finding of this study was the ability of the student nurses to engage in an authentic conversation with 'Elizabeth'. Being able to have a conversation that felt 'natural' and 'real' enhanced the authenticity of the scenario for the student nurses and lecturers and, in turn, provided an authentic learning experience for the student nurses. In Shepherd's (2014b) work, she found that young people prefer to engage in conversation with people of their own age, and such discourse promotes a sense of normalcy for young people. Therefore, in keeping with Shepherd's (2014b) findings, I propose that the conversation between 'Elizabeth' and the student nurses was strengthened owing to their closeness in age and that they were able to relate better to each other.

However, some of the students stated that having a conversation with a real patient would involve using both verbal and non-verbal communication skills and cues. As the manikins are not able to exhibit body language, for example, facial expressions and gestures, this had an impact on the conversation that some student nurses felt they could have. My findings, like those of Crowley (2013), identified that student nurses recognised that having non-verbal cues is important, as this assists with communication and the overall assessment of the patient. Furthermore, Case and Brauner (2010) suggest that a student's responses to a manikin will not evoke an empathic or caring response. They add that communicating with a 'plastic' manikin that is unable to display any non-verbal behaviour will be artificial and superficial (Case & Brauner, 2010). Some of the student nurses in this study stated that they would have acted differently if communicating with a real patient in practice, as was also reported by Davis et al. (2017) and Crowley (2013), which may have affected their ability to suspend disbelief.

A further perspective is offered by Dean, Williams and Balnaves (2016), who suggest that student nurses' communication skills are challenged when they are required to respond spontaneously to voice-over technology from a control room, and this might have an impact on their behaviour during a simulation. In this study, this was not identified as a specific issue for the student nurses, and I propose that this was because a 'real' young person was providing the voice of the manikin. The responses

from the young participant were natural and realistic, and hence the student nurses did not find it difficult to respond to the voice-over technology. In their accounts, the student nurses made numerous comments about the conversation being 'natural' and that it flowed well. Davis et al. (2017) express that an influencing factor on a simulation and its perceived reality is the ability of the learner to be able to conduct a conversation and interact with the 'patient'. However, the success of a simulation is based on the extent to which the learner engages in the scenario, as if interacting with a real person (Davis et al., 2017; Pike & O'Donnell, 2010). In order to achieve this, the student nurse must be able to fully immerse themselves in the scenario and accept that some aspects of the HFS session may not always be true to real practice. However, as noted in my findings, if the background and context of a scenario are realistic it is more likely to be accepted by students. A scenario that is developed and portrayed by young people is more likely to represent issues and situations that students of CYP nursing will face in the real world.

The desire for students to participate in and learn from 'real-world' authentic experiences is not new. For some time, students have asked for learning to be focused on real-world issues, with an increased emphasis on learning by doing as opposed to the traditional didactic method of teaching (Lombardi, 2007). The concept of authentic learning focuses on real-world, complex problems and decision-making using role-play, problem-based learning, case studies and participation in virtual communities of practice (Lombardi, 2007). Simulation is a way of achieving what Lombardi suggests are 'real-world' experiences. Although student nurses are required to undertake practice placements to satisfy the requirement for practice hours stipulated by the NMC (2018a), simulation offers an alternative 'real-world' experience. Moreover, in this study, I argue that this 'real-world' simulated learning experience was strengthened through the involvement of the young participants.

The theory of situated learning has been applied to simulation and 'real-world' experiences by a number of experts in the field (Berragan, 2011; Onda, 2012; Paige & Daley, 2009; Wyrostok, Hoffart, Kelly & Ryba, 2014). Situated learning, as first described by Lave and Wenger (1991), is based on the notion that learning occurs in the same context as it would in practice. Moreover, they suggest that learning should be more than the transference of information from provider to receiver, and the theory of situated learning is aimed at achieving this. In situated learning,

knowledge is co-constructed through social processes and occurs in physical and social environments that enable an authentic context. In turn, Brown et al. (1989) suggest that situated learning should be encapsulated in authentic activities and knowledge is transformed from a theoretically abstract to a practical perspective; in other words, the application of theory to practice. In this study, I argue that the learning of the student nurses was situated in authentic activities and they were more able to apply what they were learning to practice owing to the involvement of the young participants. As a result, a more authentic reality was created.

From the findings, it is proposed that the ability of student nurses to perceive a simulation as authentic is inherently linked to being able to apply what they see, hear and do to clinical practice, and in this case their ability to do this was enhanced through the involvement of the young participants. In Chapter 7, it was identified that participating in an authentic learning experience is inherently linked with psychological safety. Hence, I propose that the learning experiences of the student nurses were enhanced through the creation of a more authentic reality, but there were other factors at play that had a less positive effect and represented uncertainty for the student nurses.

8.4   Uncertainty

In Chapter 7, from the findings a number of uncertainties were reported and associated with the HFS sessions. These were in relation to the student nurses feeling unfamiliar with the environment, feeling unprepared, being watched and assessed and the shifting relationship in terms of academic status between the young participants and student nurses. Such factors, I argue, may have had an impact on the learning experience of the student nurses.

In simulation, learning in a psychologically safe environment relies on several important components. Turner and Harder (2018) provide a concept analysis of a psychologically safe simulated environment and identify three defining requirements for students to feel safe in simulation. These include the qualities of the facilitator, being able to make mistakes without the fear of consequences and undertaking preparatory activities. There were some instances when my findings were in keeping with Turner and Harder (2018). For instance, I identified that the student nurses felt more comfortable because they knew the facilitator. However, some were

uncertainties expressed by the student nurses about what would happen in the HFS session, and as a result some had undertaken preparatory work. Many of the student nurses reported feeling nervous or scared about the simulation session, and I had not anticipated that this would be a key finding from my research.

That said, perhaps I should have realised this, as from experience these feelings are not unusual, according to previous discussions that I have had with student nurses about simulation. For me, this challenges the notion of simulation being a safe learning environment, which is advocated in much of the literature (Rush et al., 2010; Traynor et al, 2010; Shearer, 2016). More significantly, the NMC (2018) propose simulation as a method to enable student nurses to practise skills in a safe situation. A recent integrative review reported that undergraduate students find simulation psychologically and physiologically arousing and suggest that it is challenging and stressful (Al-Ghareeb et al., 2017). In this study, many of the student nurses described feelings of anxiety or nervousness, although some were clearly more apprehensive than others. I had to consider whether the involvement of the young participants had increased these feelings for the student nurses, as they did not specifically state this in their interviews. Perhaps this was because they did not have previous experiences of engaging in HFS to compare it to. What is known from their accounts is that the student nurses were worried about how they might be perceived by the young participants and how the feedback would be articulated. However, as the interviews took place a week after the simulation sessions, they had reflected and stated that, despite such concerns, they valued the feedback from the young participants and implied that they had developed their learning. Cantrell et al. (2017) summarised that students experience moderate or high levels of stress associated with simulation; however, they confirmed that simulation is a valuable learning tool. Therefore, although learners may experience adverse physiological and psychological symptoms, a positive learning experience can still occur. This was evident in this study, as the student nurses reported that they had learnt how to communicate better with a young person and manage a difficult situation and had learnt about asthma management.

It was evident from the findings when the student nurses undertook simulation it provoked feelings of nervousness and, for some, these manifested themselves as physiological symptoms. The previous literature has suggested that simulation

provides a safe and supportive environment where learners can practise skills with no harm to real patients (Wilford & Doyle, 2006). This is undeniable; unlike in 'real' practice, in simulation a scenario can be practised repeatedly, and patients are protected from maleficence. However, this safe and supportive environment is perhaps not perceived in this way by student nurses. In the recent standards framework for nursing and midwifery education, the NMC (2018) define simulation as:

> "*An artificial representation of a real world practice scenario that supports student development and assessment through experiential learning with the opportunity for repetition, feedback, evaluation and reflection. Effective simulation facilitates safety by enhancing knowledge, behaviours and skills*" (NMC, 2018, p. 14)

For me, this is a more appropriate way of thinking about and defining simulation. This definition highlights the importance of providing 'real-world' experiences and experiential learning. However, the emphasis is on patient safety, as opposed to a safe learning experience for the students.

Simulated practice has been found to provide considerable advantages for student nurses, including improving clinical practice (Kinsman et al., 2012; McCaughey & Traynor, 2010) and increasing knowledge, critical thinking and decision-making skills (Schubert, 2012; Secomb, McKenna & Smith, 2012). However, following the interviews with the student nurses, I began to question whether simulation as a mandatory activity is beneficial for all students. Several of the student nurses expressed being very nervous about the simulation session in terms of being watched and feeling like they were being assessed, and this could have been detrimental to their learning experience. For two student nurses, these feelings were manifested as adverse physiological symptoms. However, other students stated that they felt comfortable when participating in the simulation. I wanted to understand more about why some students were more nervous than others and considered whether this could be attributed to the learning preference of the individual.

When discussing learning preferences, Garrow (2014) suggested that providing students with a choice of activities in simulation may reduce anxiety and that learning could be tailored to individual learning preferences. However, other research

identified that simulation is an effective teaching modality for all learning preferences and characteristics (Fountain & Alfred, 2009; Shinnock & Woo, 2014; Tuttici, Coyer, Lewis & Ryan, 2016). Furthermore, Brannan, White and Long (2016) found that learning styles did not affect knowledge outcomes or confidence with simulation. That said, I considered that for some student nurses observing a simulation session rather than participating might be more beneficial for their learning experience, especially with their limited exposure. Thus, in this study I contend that whereas the involvement of the young participants had discernible benefits, some uncertainties resulted from their involvement. Although I had considered whether the learning preferences of the student nurses had had an impact on their ability to feel nervous or comfortable during the simulation, there was an additional factor at play, namely, the shifting relationships in terms of academic status between the young participants and the student nurses.

A further uncertainty identified by the student nurses concerned receiving feedback from young people who were in college, with some referring to this as 'patronising'. Although I had privileged the young participants' position so that their voices were listened to, at times this was not perceived as a positive outcome. The student nurses and young participants indicated that there was a difference in status between being a university student and a college student. Similar concerns were raised in Chapter 5, where I reported that there seemed to be an accepted academic hierarchy at play. To my knowledge, there is no known research that reports on the academic hierarchy that the student nurses and young participants reported in this study. However, age in terms of being older (for the student nurses) or younger (for the young participants) raised some uncertainties. Shepherd (2014b) explored the lived experiences of younger student nurses looking after young people in hospital. She reported that the young student nurses felt like they were perceived as lacking in knowledge or experience owing to the closeness in age. Perhaps in this study this was how the young participants and student nurses felt, especially as the mature students did not identify this as an issue. I had not previously considered that closeness in age or a perceived academic hierarchy would be an issue for the participants.

8.5   Summary of chapter

To summarise, in this chapter I have drawn together the findings presented in Chapters 5, 6 and 7 and provided a critical discussion relating to how the concepts of meaningful involvement, creation of a more authentic reality and uncertainty are interconnected. For the young participants, being able to express their agency was a meaningful experience, and the student nurses valued the involvement of the young participants. The involvement enabled a more authentic reality to be experienced within a situated learning environment. However, despite such benefits, there were other factors at play that may have affected the learning experience of the student nurses.

Chapter 9

Conclusions and recommendations

9.1   Conclusions

In this chapter I highlight what this study adds to the existing body of knowledge in relation to young people's involvement in simulation. I also explain the unique contribution that this research makes to the field of CYP nurse education. When I commenced my study, I recognised that there was a gap in the literature regarding the involvement of children and young people in simulation. The findings from the literature review revealed that although listening to the voices of children in healthcare has been much more prevalent over the last ten years, their involvement in nurse education has been limited, and with regard to simulation there was no known reported research.

The aim of this research study was to answer the following question:

How do young people, undergraduate students and lecturers interpret and make sense of the involvement of young participants in simulation sessions with undergraduate students of CYP nursing?

The research question was further refined through specific research objectives and Table 9.1 provides an explanation of how these research objectives were met.

Table 9.1   Meeting the research objectives

Meeting the research objectives
1) *To identify and explore young people's accounts of their involvement in simulation sessions and any additional benefits identified by them from their engagement with a university*
Interviews with the young participants enabled them to express their views about their involvement. All three findings chapters include accounts from the YP regarding their involvement. Additional benefits are identified in Chapter 5 **Key messages:** Young people repeatedly reported how they felt listened to and their views were acted upon.

2) To identify and explore lecturers' and CYP students' insights into the benefits or drawbacks of young people's involvement in simulation sessions with undergraduate students.

Interviews with the lecturers and student nurses provided insight into the benefits/drawbacks of involving YP in simulation. The findings presented in Chapters 6 and 7 provide rich data in relation to this objective.

Key messages:
Nursing students and lecturers repeatedly reported that the simulation felt more authentic due to the involvement of the young participants.
The nursing students identified feelings of anxiety and apprehension regarding the simulation session.

3) To establish the feasibility and usefulness of embedding young people's involvement in simulation with students of children's nursing

Detailed discussion of the preparation programme establishes the feasibility of embedding YP's involvement in simulation
The usefulness is identified in Chapters 5 and 6

Key messages:
All of the participants reported positive outcomes for the involvement of young people in simulation. This study demonstrates that meaningful involvement is feasible.

4) To inform a School-wide (Health and Society) strategy regarding the involvement of children and young people in simulation

The school wide simulation strategy is currently being revised, with specific reference to involving service users (children and adults) in simulation.
I am currently developing a co-production strategy for the School of Health and Society which will be informed by the key concepts within the NSC. This is to ensure that the contribution of children and young people to the education of CYP nurses becomes everyday day practice.

Key messages:
Co-production and involvement of children and young people are essential to the development, facilitation and evaluation of curricular

5) To report and disseminate the lessons learned from working with young people in this context to add to the current body of knowledge related to young people's involvement in simulation.

Dissemination of the findings from this work is ongoing.
A post-doctoral research dissemination strategy has been agreed through my annual appraisal and specific research objectives have been agreed.

Following analysis of the data, three concepts were established: meaningful involvement, creating a more authentic reality and uncertainty. As stated in Chapter 5, the young participants reported that they felt listened to throughout their involvement in simulation and the student nurses valued the unique contributions that the young participants brought to the HFS sessions.

The young participants also reported additional benefits, including an insight into higher education and the nursing profession and developing confidence. In Chapter 6, it was identified that the involvement of the young participants enabled a more authentic reality. This included creating a realistic scenario, authentic interactions and conversations with the manikin and authentic feedback from the perspective of a young person. However, some uncertainties were also expressed by the participants, including being prepared and being watched and assessed. Although I had privileged the perspectives of the young participants, at times the student nurses were unsettled when being observed by people who were younger and less experienced than them.

Involving young participants in simulation is a new initiative, and at present there is no known existing research that reports on this. The findings demonstrate how involving young participants in simulation (from inception to delivery) had positive outcomes for young participants and student nurses; of note was the fact that the young participants felt listened to and valued following their involvement. For the student nurses, the learning experience was enhanced through the creation of a more authentic reality, and the young participants' involvement in the debriefings had positive outcomes for the student nurses.

New knowledge regarding the contributions that young participants make to the perceived authenticity of simulation has also been presented. To date, there is no previous research, as identified in the literature review, that reports on this. More specifically, my findings identify that the development of the scenario and feedback tool and the voices of the young participants enhanced the authentic learning experience for the student nurses; this is an essential requirement if students are to 'suspend disbelief' during simulation sessions.

Chapter 7 reports findings that are echoed in previous research studies (Beishel, 2013; Cato, 2013; Najjar et al., 2015; Paige & Moran, 2015) in relation to feeling

apprehensive about undertaking simulation and, more specifically, how this could have an impact on a psychologically safe learning experience. The student nurses reported feeling anxious and nervous before, after and during an HFS session. However, the findings presented in this study add that the involvement of the young participants could be implicated in feelings of uncertainty, which I contend is a new finding.

Thus, in summary, from undertaking my research I have established several new findings that have not been reported elsewhere in the literature.

The three core concepts are inextricably linked. The association between the meaningful involvement of young participants in simulation and enhancing the authentic reality was notable. The views of the young participants were privileged, and this resulted in an enhanced authentic reality in simulation for the student nurses. This was achieved through several mechanisms:

- the writing of the scenario, which enabled a realistic context for the scenario (authenticity);
- the young participants providing the voice of the manikin (involvement) enabled 'real' conversations to take place (authenticity); and
- devising the feedback tool and participating in the debriefings (involvement) enabled the feedback to be valued by the student nurses and be genuine (authenticity).

These mechanisms resulted in young people making a meaningful contribution to the education of students of CYP nursing when undertaking simulation; in particular, the young people felt valued and listened to when contributing to the education of students of CYP nursing. The student nurses valued the involvement and the contributions that the young participants brought to the simulation sessions. The young participants helped to create a more authentic reality in the simulation sessions by bringing to the fore their subjective understandings regarding the contemporary lives of other young people.

However, it was also noted that being observed by and receiving feedback from the young participants were implicated in a degree of uncertainty for the student nurses, both before and during the simulation sessions. That said, they acknowledged the

value and impact on their learning for practice and hearing from their 'patients' rather than their patients' parents. Many spoke about the importance of receiving feedback from young people and how this would inform their practice going forward.

A key strength of this work is that it is in the vanguard of developing simulation practice. This study is the first to report on the involvement of young people in the planning, facilitation and debriefing of HFS sessions with undergraduate students of CYP nursing. Furthermore, this work contributes significantly to advancing the body of knowledge in relation to co-production with children and young people and I suggest the methods can be used by those working in health and social care education to effectively involve CYP.

As noted in Chapter 2, the NSC had much to offer this study by detailing the importance of the key concepts of voice, choice and agency when meaningfully engaging with young people. I contend that, if incorporated into the current models of coproduction (see the OCC Wheel of Participation (2012) and NHS model of coproduction (Coalition for collaborative care, 2016) they would further help others, as they did me, to understand more fully how to work effectively with young people as valued assets, regardless of the research or project intention.

The model of co-production (Coalition for collaborative care, 2016) asserts that stakeholders should build coproduction into programmes of work and continue to do so until it becomes everyday practice. I contend that adapting the current models to include the key concepts of voice, choice and agency would help others to work effectively with young people so that their contribution is valued and also becomes everyday practice.

In this way, the findings from this study advance the evidence-base of not only how to build coproduction, but they offer insight into the methods that can be used to ensure tokenistic involvement with young people is avoided. For instance, the time of day, day of the week, and duration of the training days proved important as this was organised around the young participants' college timetables. As noted in chapter 4, it was essential that I provided a welcoming environment, used a variety of engaging activities and avoided planning days that were too intense or included the delivery too much new information for the young participants.

The methods used for the preparation programme and findings from this research can be used as guidance for policy makers, higher education institutions and health providers regarding successful coproduction. Further, this is not limited solely to CYP nursing programmes but could be applied to a variety of educational programmes that use simulation. Oliver, Kothari and Mays (2019) suggest that to coproduce services effectively involves investment, time and skills. In my study there was minimal financial investment required, but a significant amount of time was invested in the preparation programme. While challenging and adding to heavy workloads, the investment reaped rewards for all those involved in this study and should be implemented by others committed to seeing young people as valuable assets.

When I started this work, the concept of co-production was rare and not often included in the development and design of services or the education of health care staff. Since, and as noted by Holland-Hart, Addis, Edwards, Kenkre and Wood (2018) the concept of co-production is becoming more established in health care. However, despite this, they purport that there is a requirement to provide more precise guidance for health organisations, education providers and governments about what constitutes coproduction. In turn, Oliver et al (2019) suggest that there is a paucity of published evidence that reports on the impact of coproduction on policy, practice and research. I contend that this study provides new and robust evidence on the coproduction of high-fidelity simulation sessions and furthermore, identifies positive outcomes for all those involved. There is no doubt that coproducing the simulation sessions enhanced the learning for the student nurses and was a valuable experience for the young participants. It is reasonable to assume that the lessons and positive outcomes learned from this project are transferable to other research and projects seeking meaningful involvement with young people,

Overall, the findings from this work are positive, and further involvement of young people across other simulation sessions could enhance the learning of students of children's nursing, as well as other fields. This study has provided new and unique insights into the benefits of involving young people in simulation.

9.2   Strengths and limitations of the study

Mason (2018) and Sandelowski's (2000) work inspired me to resist the temptation to use a well-established research approach. Rather, in keeping with my ontological

and epistemological standpoint, I adopted an exploratory, interpretive approach, which proved valuable for this work in eliciting the subjective insights of the participants. Therefore, a significant strength of this work is the unique reporting of subjective views, from multiple perspectives, of involving young people in simulation. The views of the young participants, student nurses and lecturers were sought, and, at the time of writing, this was the first study to report on this. In turn, the views and positioning of the young participants were privileged. Further, this study provides a transparent and clear process of working with young people and involving them in simulation.

A limitation is that the findings from this study are not generalisable. As Creswell (2014) suggests, the purpose of qualitative research is not to apply the findings to people or places outside those being studied. However, I did not intend to produce findings that would be generalisable; rather, the objectives of this work were to develop insights into involving young people in simulation and to understand more fully how this could inform future work. A further limitation of the study was identified in relation to the number of student nurses who did not participate in the focus group interviews (n=6). Had they done so, they might have added to what is reported or offered different insights. That said, the right to refuse participation was paramount, and therefore, although I made some attempts to involve these students, their right not to participate was respected.

There were also some limitations in relation to my role as the researcher. I was undertaking a doctoral programme with little previous experience of research, and there were some aspects that challenged me. The analysis of data was particularly demanding. Despite following the stepwise framework method described by Ritchie et al. (2003), I found the process of moving back and forwards across the data an arduous and sometimes unforgiving task. However, I realise now that this was an essential part of the analysis to ensure the robustness of the findings. In addition, there were many occasions when the findings were deliberated and challenged by myself and my supervisors. I came to understand that I had to ensure what I was arguing was made transparent through the analysis process, a process that I now know enhanced the rigour of the study.

I also encountered many challenges when working with busy young people and the significant role that the gatekeeper played in their recruitment and involvement. However, an additional strength of this study was the facilitation of the preparation programme with the young participants. The young participants were engaged in the planning of the HFS session immediately and were instrumental in the co-production of the session and feedback tool. I spent a significant amount of time working and engaging with the busy young participants and, as a result, succeeded in maintaining their interest, commitment and enthusiasm throughout the study. Hence, similar preparation programmes could be adopted when working with younger children and adult service users in the co-production and facilitation of simulation sessions.

9.3 Recommendations

In this section I provide a summary of recommendations resulting from my findings. These are subdivided into recommendations for nursing research, nursing education and nursing practice and policy.

9.3.1 Nursing research

Following the presentation of findings and discussion, there are some areas within this field that require further exploration. This study explored the involvement of young people in simulation. **Recommendations for future research include undertaking similar work with younger children and evaluating the outcomes of their involvement in simulation.** The CYP@Salford research group have links with a number of local schools and have successfully undertaken research with younger children. Therefore, using these established links, further research into involving younger children in simulation could be conducted.

The young participants had developed the feedback tool and used this to guide their feedback. The tool was used successfully by the young participants in this study, but further refinement and testing of the tool are required to validate its benefits. In addition, the feedback provided to the student nurses in the debriefings was not analysed, as this was not part of the research aims and objectives. **Therefore, a recommendation is to analyse the written comments on the tool and the feedback that was delivered to the student nurses in the debriefings.**

Despite some concerns raised about the young participants' involvement, numerous benefits were recognised, which outweighed these. All the student nurses in the study experienced the involvement of the young participants. **A further recommendation for research is to undertake an experimental study comparing the experiences of student nurses with and without the involvement of young participants in an HFS session**. It was noted that many of the student nurses in my study experienced feelings of apprehension and nervousness before, during and after the simulation. **As part of the experiment, a recommendation would be to measure anxiety using a validated tool and compare the results from the two groups.**

9.3.2 Nurse education

In keeping with the NMC standards framework for nursing and midwifery education (NMC, 2018a), HEIs need to demonstrate that the design, development, delivery and evaluation of curricula are co-produced with service users. This is applicable to the planning, facilitation and debriefing of simulation sessions. The involvement of the young people in simulation had clear benefits for the student nurses, most significantly in enhancing the authenticity of a simulated practice experience. There was a consensus that the scenario, voice-over, interactions with the manikin and debriefings offered a more authentic experience owing to the young participants' involvement. There was no known research that reported on this. **Therefore, a national recommendation is that the involvement of children and young people in simulation is integrated throughout undergraduate nursing curriculum.** A current paper is in preparation, focusing specifically on the preparation programme described Chapter 4. The paper will include useful hints and tips for working with young people and provide a step-by step guide on how to coproduce simulation sessions with young people. Below are some recommendations and considerations of working with young people:

- Consider carefully the start and finish times of workshops. In the afternoons the young participants were tired and appeared less motivated
- Ensure that young people are involved from the outset (designing a scenario) to the debriefing

- Listen-to and act on what young people tell you. Be prepared to have your own views challenged
- Provide thorough and regular orientations to the simulation environment and manikins
- Provide the young people with just a broad outline of a scenario – give them the freedom to create the background, social history and context of the simulation scenario
- Use multiple and engaging strategies such as diamond ranking, body maps, practical demonstrations
- Provide support/recommendations for the clinical aspects of the scenario
- Establish a good relationship with college tutors – they will be your gatekeepers

It was identified that some of the feedback that was delivered to the student nurses was brief and that some of the young participants felt nervous about delivering feedback. **Therefore, it is recommended that if young participants are engaging in feedback for the first-time further training is provided to ensure that they feel competent and confident with the process**. The young participants had observed a debriefing, but it would have been beneficial if they had participated in some mock feedback sessions.

Some of the student nurses were unable to suspend disbelief owing to the inanimate nature of the manikin; more specifically, they referred to the lack of body language. In the HFS sessions, it was necessary to use a manikin owing to the physiological changes; however, in some HFS sessions this is not always the case and 'real' people can play the role of the patient. **Therefore, it is a recommendation that children and young people are involved as simulated patients.** This could be, for example, when a scenario focuses on communication with a child or young person with autism or someone who has self-harmed.

Some notable uncertainties were reported by the student nurses regarding the HFS session, and these affected their ability to have a psychologically safe learning experience. These included being unfamiliar with and unprepared for simulation, being watched, being assessed and the shifting relationship between the young participants and student nurses. Although there are benefits to streaming live with

others watching in another room, drawbacks were noted. **A recommendation is to limit the number of people observing student nurses when participating in a simulation, especially if this is for the first time.** If young people are involved in the future, observation could be carried out by just two young participants who are observing from a control room. This may mitigate some of the concerns about a group of people observing from another room. As an alternative, the HFS session could be recorded and feedback could be provided by young participants later once the recording had been reviewed.

Following the interviews with the student nurses, it emerged that, at times, some of the actions that the student nurses carried out and conversations that they had with the manikin were not representative of how they would act in practice. It was established that those who had participated in a simulation previously found the experience less 'scary', with other student nurses explaining that some of their worries related to the lack of exposure to simulation that they had received. **Therefore, it is recommended that HEIs increase the amount of simulation that student nurses are exposed to.** If simulation is integrated from the beginning of the programme and there is meaningful exposure throughout, they will ultimately feel more comfortable. Since these HFS sessions were undertaken in 2015 there has been a significant increase in the use of simulation in the undergraduate nursing curriculum; however, there are still opportunities to increase this further.

In turn, it is essential that facilitators do not state that simulation provides a safe learning environment; what is more appropriate is the notion that simulation creates a safe environment for the patient or person, in that no 'real' harm can come to them if mistakes are made. **It is recommended that all faculty engaged in simulation emphasise that simulation facilitates patient safety through experiential learning and refrain from stating that simulation is a safe and supportive learning environment.**

9.3.3 Nursing practice and policy

The NMC (2018a) highlight the need to embed simulation and technology-enhanced learning into curricula. Furthermore, HEIs can substitute practice hours with simulation, and currently no minimum or maximum number of hours is stated. At the time of writing, I am involved in the planning of a new nursing curriculum that will

substitute practice hours with simulation. **A further recommendation is to ensure that the simulated practice is authentic, and this will be achieved through the involvement of service users.**

As noted in Chapter 1, NHS England (2016) devised a seven-step co-production model; however, this is a generic model and is not specifically designed for children and young people. **A recommendation is to adapt this model so that it can be specifically applied to co-production with children and young people**. This could be achieved by integrating the principles identified in the OCC Wheel of Participation (2012) (see also Chapter 1).

Health Education England (HEE) (2018) published the National Framework for Simulation Based Education (SBE). The framework states that SBE should be meaningful and cohesive; however, there is no reference to the involvement of service users in this framework. **A recommendation is to develop a co-production strategy for simulation that would support the HEE framework and be implemented nationally**.

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APPENDIX 1)

Engagement Ethical Approval Panel
College of Health & Social Care
AD101 Allerton Building
University of Salford
M6 6PU
T +44(0)161 295 7017

24 June 2014

Dear Amanda,

RE: <u>ETHICS APPLICATION HSCR14/29</u> – Exploring the involvement of young people in high fidelity simulation (HFS) with students of children's and young people's nursing

Based on the information you provided, I am pleased to inform you that application HSCR14/29 has been approved.

If there are any changes to the project and/or methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth

College Support Office (R&I)

APPENDIX 2)
Participant information sheet for young people

Title of project:
Exploring the involvement of young people in helping students of children's nursing to learn using mannequins

The Study:
I would like to invite you to take part in a research study. Before you decide whether or not you wish to take part it is important that you understand what the research is about and why it is being carried out. Please take enough time as you need to read through the information on this sheet. Ask questions if there is anything that you are unsure of or don't understand. Take your time deciding whether you would like to take part.

The aim of this study is to involve young people in helping students of children's nursing to learn using mannequins. Another term for this type of learning is High Fidelity Simulation (HFS). For a demonstration on YouTube please go to:
http://www.youtube.com/watch?v=XNYA4F19GyU
HFS uses mannequins instead of real people so that nursing students can learn safely. The mannequins can be programmed to talk, breathe, sweat, and bleed. I would like you to help me to make the use of the mannequins as realistic as possible. This could involve helping me to write stories about the mannequins, being the voice of the mannequin, watching nursing students to nurse the mannequins and giving them feedback on what they did.

What is the purpose of the study?
This study is part of my PhD that I am doing at the University of Salford.
As part of this work I want to work with young people so that they have a say and are able to contribute to the learning of nursing students working in the field of children and young people's nursing.

Why have I been invited?
I am inviting you because you are studying or have an interest in health and social care.

Do I have to take part?
No – participation is completely voluntary and it is up to you to decide whether you would like to take part. If you decide to take part now you will be able to change your mind at any time without needing to give me a reason. You will even be able to withdraw during the days at the University as a university lecturer will be available to stay with anyone that changes their mind about taking part. However I may not be able to take out any information that you have given me up to this point.

What will happen to me if I take part?
If you decide to take part you will be required to attend the University on 4 different days over a period of 3 months. These days will be agreed with you and your school or college so that they do not interfere with your studies or examinations. Each day will last between four and five hours. The first day will consist of telling you more about the study and

teaching you about the mannequins. The second day will be spent writing the stories and learning how to observe the nursing students. The last two days will be spent observing the student nurses and giving feedback to them. You will also be invited to take part in an interview during which I will ask you about your experience of taking part. You can decide if you would like to be interviewed by yourself or with other young people. This interview will take place at school or college and will last for about one hour, longer if you wish. When the study is complete I will come and tell you what I have found out and let you know if other young people will be involved in the future.

Expenses and payments

I will make any necessary transport arrangements from school or college to the University. Lunch and refreshments will be provided throughout each day. You will also receive a certificate and a letter explaining what training you have undergone and the skills you have developed through your involvement.

What will I have to do?

You will be expected to attend on four days at University and you will be asked to observe and feedback to student nurses. You will also be asked to attend an interview held at your school or college.

What are the possible disadvantages and risks of taking part?

It is extremely unlikely that anything you do will lead to you feeling upset. However you may feel uncomfortable giving feedback to students especially if this involves telling them that they did something that you didn't like. A university lecturer will be present for the conversations that you have with the nursing students so that no one says anything wrong or gets upset about what is being said. Although very unlikely, it is possible that you may get upset or worried once the mannequins are switched on and in operation. Before you take part in the research I will make sure that you feel happy and comfortable with what will happen with mannequins in the HFS session. However if you do become upset during the HFS session a lecturer will be there to take you out of the room and stay with you and you will not have to go back into the room if you don't want to.

What are the potential benefits of taking part?

We can not promise that the study will benefit you but it is hoped that this will enhance the care that student nurses deliver to children and young people. It may also help you think about your future and whether you would like to pursue a career in health care.

What if there is a problem?

If you have any worries or concerns or wish to make a complaint then please contact Anish Kurien. Telephone: 0161 2955276 or email: a.kurien@salford.ac.uk

Will anyone find out what I have said?

While I will be using what you have said in written reports, presentations and teaching sessions I will never use your name or any identifying details about you. I am bound by the Data Protection Act (1998) and will ensure that information about you and what you say will be kept securely at the University. All information will be destroyed once the study is complete.

Further information and contact details

Main researcher: Amanda Miller email a.miller@salford.ac.uk. Tel: 0161 2952701

APPENDIX 3)
Participant information sheet for students

Title of project:
Exploring the involvement of young people in helping students of children's nursing to learn using mannequins

The Study:
I would like to invite you to take part in a research study. Before you decide whether or not you wish to take part it is important that you understand what the research is about and why it is being carried out. Please take enough time as you need to read through the information on this sheet. Ask questions if there is anything that you are unsure of or don't understand. Take your time deciding whether you would like to take part.

The aim of this study is to involve young people in helping students of children's nursing to learn using mannequins. Another term for this type of learning is High Fidelity Simulation (HFS). For a demonstration on YouTube please go to:
http://www.youtube.com/watch?v=XNYA4F19GyU
HFS uses mannequins instead of real people so that nursing students can learn safely. The mannequins can be programmed to talk, breathe, sweat, and bleed.

I would like you to participate in one HFS session. During this session one young person (YP) will be the voice of the mannequin and another one or two will observe you. Following all HFS sessions the facilitator debriefs the students and the YP will be involved in this too. We are involving young people to help us write the scenarios, be the voice of the mannequin, observe you participating in a scenario and be included in the debriefing.

What is the purpose of the study?
This study is part of my PhD that I am doing at the University of Salford.
The purpose of this study is to work with young people to help them get their voices heard. It is important that young people have a say and are able to contribute to current and future healthcare and in particular the education of student nurses who are working in the field of children and young people's nursing.

Why have I been invited?
I am inviting you because I am seeking the participation of CYP nursing students at the end of their second year.

Do I have to take part?
No – participation is completely voluntary and it is up to you to decide whether you would like to. I will describe the study to you and go through the study information sheet. I will then ask you to sign a consent form. This lets me know that you have agreed to take part. However you are free to withdraw from the study at any point without having to give a reason.

What will happen to me if I take part?

The duration of the study will be approximately 3 months but your input will be required on 3 days within this time period.

Expenses and payments
Travel costs to and from the venue out of University theory hours will be covered by the researcher. Lunch and refreshments will be provided throughout each day.

What will I have to do?
You will be expected to attend all of the three days which includes the orientation and training days. After the HFS session you will be asked to return on another day to participate in a focus group discussion. If you are unable to attend any of the days then we would ask you to contact us as soon as possible.

What are the possible disadvantages and risks of taking part?
There may be times when you receive feedback which may seem critical. Therefore the facilitator of the scenario will help the young person deal with this sensitively and make sure that any upset is minimised. Again the facilitator is there to ensure that you are supported and lead the debriefing so that any issues are dealt with appropriately. Should such a situation arise then following this there will be mechanisms in place to support you with this.

What are the potential benefits of taking part?
We can not promise that the study will benefit you but it is hoped that this will enhance the care that you deliver to children and young people.

What if there is a problem?
If you have any worries or concerns or wish to make a complaint then please contact Anish Kurien. Telephone: 0161 2955276 or email: a.kurien@salford.ac.uk

Confidentiality
While I will be using what you have said in written reports, presentations and teaching sessions I will never use your name or any identifying details about you. I am bound by the Data Protection Act (1998) and will ensure that information about you and what you say will be kept securely at the University.

Further information and contact details
Main researcher: Amanda Miller email a.miller@salford.ac.uk. Tel: 0161 2952701

APPENDIX 4)
Participant information sheet for lecturers

Title of project:
Exploring the involvement of young people in helping students of children's nursing to learn using mannequins

The Study:
I would like to invite you to take part in a research study. Before you decide whether or not you wish to take part it is important that you understand what the research is about and why it is being carried out. Please take enough time as you need to read through the information on this sheet. Ask questions if there is anything that you are unsure of or don't understand. Take your time deciding whether you would like to take part.
The aim of this study is to involve young people in helping students of children's nursing to learn using mannequins. Another term for this type of learning is High Fidelity Simulation (HFS). For a demonstration on YouTube please go to:
http://www.youtube.com/watch?v=XNYA4F19GyU
HFS uses mannequins instead of real people so that nursing students can learn safely. The mannequins can be programmed to talk, breathe, sweat, and bleed.
I would like you to facilitate the scenario and guide the debriefing with the student's alongside the young person.

What is the purpose of the study?
This study is part of my PhD that I am doing at the University of Salford
The purpose of this study is to work with young people to help them get their voices heard. It is important that they have a say and are able to contribute to current and future healthcare and in particular the education of student nurses who are working in the field of children and young people's nursing.

Why have I been invited?
I am inviting you because you have experience in facilitating high fidelity simulation and work in the field of children and young people's nursing.

Do I have to take part?
No – participation is completely voluntary and it is up to you to decide whether you would like to. I will describe the study to you and go through the study information sheet. I will then ask you to sign a consent form. This lets me know that you have agreed to take part. However you are free to withdraw from the study at any point without having to give a reason.

What will happen to me if I take part?
The duration of the study will be approximately 3 months and you will be required on 4 days during this period.

What will I have to do?

You will be expected to attend on four days which includes the orientation and training days. You will be asked to participate in a HFS session and then return to participate in a face to face interview. If you are unable to attend any of the days then we would ask you to contact us as soon as possible.

What are the possible disadvantages and risks of taking part?
It is extremely unlikely that anything you do will have any disadvantages or risks. However there is a possibility that the young person may become upset and distressed when the mannequins are in operation. You will be expected to help escort the student from the room and another lecturer will be there to take over and to support and comfort the young person.
Also young people may feel uncomfortable giving feedback to students especially if this involves telling them that they did something that they didn't like. You will be present for the conversations that the young people have with the nursing students and you will be expected to ensure that no one says anything wrong or gets upset about what is being said.

What are the potential benefits of taking part?
We can not promise that the study will benefit you but it is hoped that this will enhance the care that student nurse's deliver to children and young people.

What if there is a problem?
If you have any worries or concerns or wish to make a complaint then please contact:
Anish Kurien Telephone: 0161 2955276 or email: a.kurien@salford.ac.uk

Confidentiality
While I will be using what you have said in written reports, presentations and teaching sessions I will never use your name or any identifying details about you. I am bound by the Data Protection Act (1998) and will ensure that information about you and what you say will be kept securely at the University.

Further information and contact details
Researcher: Amanda Miller email a.miller@salford.ac.uk. Tel: 0161 2952701

APPENDIX 5)

Interview topic guide for young participants

1. How have you found participating in the education of CYP nurses?

2. Have you felt that you have benefited from being involved in this experience?

3. What did you think about the workshops that you attended to prepare you for the simulation day? (Including the qualities, devising the feedback tool, writing the scenario.) Did you feel prepared enough for the simulation?

4. Would you have liked any more training or development prior to the simulation day?

5. How did you feel about observing the students? Do you think that the observation tool was fit for purpose?

6. Was there anything about participating that you didn't enjoy?

7. What did you think about observing the student nurses and during the feedback/debriefing?

8. How did you feel about being the 'voice' of the young person?

9. How do you think the student nurses received your feedback? Do you think that they will benefit from it?

10. Was there anything that could have been done differently?

11. Would you recommend this to other students to get involved in this?

Any other comments you would like to add?

APPENDIX 6)
Interview topic guide for students in focus groups

1. Prior to the simulation day how did you feel about the preparation you were given (including meeting the YP)?

2. Did you feel you knew why the YP were being involved in your simulation?

3. Is this your first experience of using the manikins? Have any of you done simulation in the optional modules?

4. Before you started the simulation session, how were you feeling? What were your expectations?

5. What did you think about the voice of the manikin, namely, one of the YP?

6. How did you feel knowing that the YP were observing you and, in particular, your interpersonal/attitudinal skills?

7. The YP wrote most of the background to the scenario – what did you think about it?

8. In the debriefing the YP were involved in giving you some feedback – how did that go?

9. How do you think that the YP contributed to your development as a CYP nurse?

10. Are there any drawbacks from having the YP involved?

11. How would you feel again about having service users and carers involved in simulation?

12. What would you say to other students about this experience?

13. How have you felt being involved in a research study?

14. Is there anything else that you want to add?

APPENDIX 7)

Interview topic guide: lecturers

1. Prior to the simulation session did you feel adequately prepared regarding the involvement of young people in this simulation session?

2. Would you have liked any more training or preparation?

3. What did you think about the young person providing the voice of the manikin?

4. How did you feel about the young people observing?

5. Based on your own experiences of facilitating simulation, do you feel that it made a difference to the nursing students knowing they were being observed?

6. What did you think about the contributions that the young people made?

7. Were the nursing students receptive to the feedback during the debriefing?

8. Do you think that the young people's involvement will help develop the skills of nursing students?

9. What was the feedback like that the YP provided?

10. How did you feel having the YP with you during the debriefing?

11. Do you think that young people's involvement in simulation should be embedded into other modules/programmes?

12. Is there anything else you would like to add?

APPENDIX 8)

SESSION PLAN

DAY 1:   ORIENTATION FOR THE YOUNG PARTICIPANTS

VENUE: Mary Seacole Building MS223

DATE: 5TH MAY 2015

TIME: 10.00 – 16.00

Present: xxxxxx (researcher), young people (15), college tutor, xxxxxx
           (supervisor), xxxxxx (technician), nursing students (12-1)

TIME	ACTIVITY	RESOURCES
10.00 – 10.30	Refreshments and welcome, housekeeping	MS260 (classroom) Tea/coffee/juice/biscuits
10.30 – 12.00	Orientation to the simulation labs and clinical skills rooms Young participants to meet the manikins	MS223, MS233, clinical skills rooms, meet technical staff SimNewB®, SimBaby®, SimJunior®, Nursing Anne®
12.00 – 12.45	Meet the students, introduce them to project Two students to talk to YP why they chose to study nursing	MS193
12.45 – 13.30	Lunch	MS261
13.30 – 14.00	Demonstration of a simulation session	Manikin
14.00 – 14.30	Group work activity (seeking the views of the YP)	Flipchart, pens and Blu-Tack
14.30 – 14.45	Comfort break and refreshments	
14.45 – 15.15	Feedback from group work	
15.15 – 15.45	Questions and answers Plans for next session (9th,17th or 23rd June)	Post-it notes
15.45 – 16.00	Close	

APPENDIX 9)

Observations and feedback from young people during the high-fidelity scenario

Communication (For example: being patient, being listened to and being caring)

Respect (For example: privacy and confidentiality, providing information, asking for consent)

Attitude (For example: a positive attitude, talking directly to the patient, providing reassurance)

APPENDIX 11)

SCENARIO

Elizabeth Smith, 15 years old

Date of Birth 24th December 1999

Background

Elizabeth was with her boyfriend in the car, and he's been smoking (a lot) – asthma attack came on quite suddenly, became short of breath, started wheezing. Boyfriend brought her to A&E but hasn't stayed as he knows that her dad is on his way.

Elizabeth is currently in A&E waiting to be assessed by a student nurse and is having an argument with her dad. Dad not happy about the situation with her boyfriend, thinks he's a bad influence. Dad says that he is going off to call mum. Elizabeth starts to feel worse as she is becoming stressed about the situation with her dad and boyfriend.

Family history

Mum (Lisa), dad (Pete)

2 x brothers (aged 7 and 10, John and Michael), 1 x sister (Vicky)

Education

Studying GCSEs, quite stressed about it. Taking Geography, History, German, PE, Music.

Hobbies

Trampolining, Morris dancer, swimming, likes going out with friends.

Medical history

Diagnosed with asthma when 9 years old, no other medical problems.

Had a few admissions to hospital, but more recently. Last admission 3 months ago, but was discharged home on the same day, but had to go to the asthma clinic for them to look at the medication but missed the appointment.

Boyfriend – 17 years old (Edward), not very supportive re asthma and is embarrassed about her carrying the inhaler. She's not been taking it much because of this.

Current medication

Takes a blue and orange inhaler – doesn't know what the name of the medication is. Supposed to use a spacer 'thing' but thinks it's stupid-looking.

Physical symptoms

Wheezing, breathless

Heart rate = 100   Respiratory rate = 25   Oxygen saturations 92% in air   Temp 38

Student nurse should apply oxygen, Elizabeth starts to deteriorate (oxygen saturations now 88%) – student nurse needs to call for help.

Elizabeth getting anxious, not happy about staying in A&E, wants to go home, never had a nebuliser.

APPENDIX 12)

FACILITATORS' GUIDE

Scenario title: Young person with an acute exacerbation of asthma

Participants: CYP nursing students, end of 2nd year

Academic staff: 3 x facilitators (1 x facilitator, 1 x in observation room, 1 x role-play dad/mum)

Young people: 1 x voice of manikin, others to observe

Technician: To operate manikin (Nursing Anne)

Background to scenario

Elizabeth Smith is a 15-year-old girl (DoB 24th December 1999). She was diagnosed with asthma when she was 9 years old and has had several hospital attendances over the last few years.

Elizabeth was with her boyfriend (Edward) in his car, and he had been smoking with the windows almost closed for most of the time. Elizabeth has been coughing more recently but became quite distressed in the car, coughing more, and felt short of breath and began wheezing.

They came to the paediatric observation and assessment unit together, but Edward left as he saw Elizabeth's dad arrive. Dad has been expressing his concern to Elizabeth for some time about Edward and thinks he's a bad influence.

Elizabeth says that her boyfriend doesn't understand about her asthma and is not supportive; he gets embarrassed when she gets her inhaler out and therefore she has not been taking it regularly.

Learning outcomes

1) To communicate effectively with the young person, provide introductions and demonstrate sound interpersonal skills
2) To perform appropriate physiological observations according to the presenting condition and adhere to the RCN guidelines (RCN, 2013)
3) To initiate and perform a respiratory assessment identifying effort, efficacy and effect (ALSG, 2011)
4) To assess severity of asthma according to the British Thoracic Society (BTS, 2014) guidelines and initiate appropriate treatment (objective no. 5)
5) Under supervision of mentor prepare and administer salbutamol nebuliser and commence oxygen therapy as required
6) Identify whether the young person is responding appropriately to treatment
7) To recognise the potential for conflict and act appropriately
8) To call for help as required at any point during simulation

Family history
Mum (Lisa), dad (Pete) – no medical problems

2 x brothers (7 and 10, called John and Michael); 1 x sister (Vicky)

Education

Studying GCSEs and is quite stressed about her final year, feels under pressure to do well. Has chosen Geography, History, German, PE, Music. She wants to be a police officer when she is older.

Hobbies

Trampoline lessons, swimming, Morris dancer (but she is starting to struggle with these owing to her asthma), likes going out with friends

Medical history

Diagnosed with asthma when 9 years old, no other medical problems.

Had a few admissions to hospital, but more recently. Last admission was 3 months ago but was discharged home on the same day. She was supposed to go to the asthma clinic the following week to have her medication reviewed but missed the appointment.

Current medication

Takes a blue and orange inhaler - not sure what the name of it is. She says she is supposed to use a 'plastic thing' (spacer) with her inhalers but finds it really embarrassing and too big to carry around.

Handover to be given to nursing students

You are working in the observation and assessment unit with your mentor, and a 15-year-old girl (accompanied by dad) is waiting for triage. Your mentor asks you to go and do a respiratory assessment and perform some physiological observations.

Mentor – to be around should the student need help, prompt only if required, bring prescription and oversee administration of oxygen/salbutamol. Ensure that a discussion is initiated about the use of steroids.

Initial presentation

As student nurses approach, Elizabeth and dad are having quite a heated discussion about Edward, and dad decides that he has had enough and leaves to call mum. He is happy for the student nurses to carry on their assessment without him. Throughout the scenario Elizabeth will be anxious, wanting to go home, and not particularly cooperative and will challenge the student nurse.

On assessment - Audible wheeze, short of breath, tight chest and feels unwell.

Initial physiological observations

HR 100 SAO2 92%   RR 25   Temp 38   BP 105/60

Further deterioration (with or without oxygen, about 5 minutes into scenario)

HR 110 SAO2 90%   RR 28   Temp 38   BP 115/64

Improvement (after about 3 minutes of receiving the nebuliser)

HR 110 SAO2 95%   RR 22   Temp 37.8   BP 100/52

*Scenario will finish when the mentor observes that Elizabeth's condition has improved, and she is calm and reassured.