Accepted Manuscript

Preparation for workplace adversity: Student narratives as a stimulus for learning

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PII: S1471-5953(17)30320-7
DOI: 10.1016/j.nepr.2017.05.008
Reference: YNEPR 2228

To appear in: Nurse Education in Practice

Received Date: 14 August 2015
Revised Date: 30 August 2016
Accepted Date: 17 May 2017

Please cite this article as: Hanson, J., McAllister, M., Preparation for workplace adversity: Student narratives as a stimulus for learning, Nurse Education in Practice (2017), doi: 10.1016/j.nepr.2017.05.008.

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Title page:

PREPARATION FOR WORKPLACE ADVERSITY: STUDENT NARRATIVES AS A STIMULUS FOR LEARNING

Full word count: 4,999 words excluding references – 6,186 words with references

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ACKNOWLEDGEMENT

Thank you to Central Queensland University (CQU) for supporting this work.
RESEARCH HIGHLIGHTS

• Nursing students are not always well prepared for workplace adversity

• Health care culture contributes to nursing students’ experiences of adversity

• Learning challenges prior to practice are important in empowering students

• Assisting students to critique culture helps in reframing adverse events

INTRODUCTION

Workplace adversity is a common experience for nurses worldwide and this includes nursing students. Whilst students may expect to find nursing a stressful occupation, many studies have revealed that students are not anticipating the degree of distress that they will feel, and nor do they appreciate the multiple sources for the stress that leads to adversity (Grafton et al., 2010; Hamshire et al., 2012; Leducq et al., 2012). One stressor getting wider attention is healthcare culture (Laschinger et al., 2012; Levett-Jones et al., 2008; Lumby, 2008; Thomas, 2012; Youngson, 2011).

In the current global climate of health workforce shortages there is pressure on higher education providers to supply industry with work-ready graduates, though how to achieve this remains contentious (El Haddad et al., 2013; Levett-Jones et al., 2006; Wolff et al., 2010). It is a challenging mandate but academics and industry partners acknowledge that the university curriculum plays a vital role in developing nursing student readiness for practice through lectures, tutorials, simulation, online modules, and clinical laboratories. This preparation is consolidated in clinical placement and internship (Brown et al., 2011; Levett-Jones et al., 2015). Early professional
socialisation is recognised as crucial for future nurses to understand the values that underpin the profession and includes raising awareness about the dissonance that students experience between their idealised view of nursing and the realities of practice (Mackintosh, 2006; Price, 2009). However, despite formal education directed at socialisation and transition into practice nursing students may still fail to notice the impact of prevailing health care ideologies on their own practice and unwittingly perpetuate the status quo, by for example accepting hostile behaviours, and even reproducing them when they themselves become qualified practitioners (Kelly and Ahern, 2008).

Health care culture has a significant influence on how a student is socialised to their professional role (Kelly and McAllister, 2013; Hegenbarth et al., 2015) and yet few research studies have explored the learning that occurs when nursing students are assisted to critically reflect on adverse events and critique cultural sources. Moreover, minimal attention has been given to the contribution that nursing students can make when they partner with educators to devise lesson plans that might facilitate students’ preparedness for practice. As part of a larger study exploring the role of the curriculum in preparing nursing students to cope with workplace adversity, this analysis reveals what learning students identify as valuable to future nursing students preparing for clinical placement and makes educational recommendations drawn from student input.

**BACKGROUND**

Adversity is a complex phenomenon. Some existing definitions of the term ‘adversity’ associate negative events with negative personal consequences and focus on adversity as a predictor of maladjustment (Neff and Broady, 2011). Such narrow
definitions of adversity do not encompass the capacity for positive adaptation that people often exhibit in the face of adversity (Davydov et al., 2010); nor do they contextualise how adversity is defined in different populations and manifests in diverse practices (Ungar and Lienbenberg, 2011). A number of studies have identified that nursing students experience adversity as being unable to deliver patient care in the way that they were taught to at university, difficult transitions into practice, being socialised into negative workplace cultures and, being a target of workplace violence (Laschinger et al., 2012; Levett-Jones et al., 2015; MacIntosh, 2003; Sharp et al., 2015; Pearcey and Draper, 2008; St.Pierre, 2012; Thomas and Burke, 2009). This difference between learning and practice often creates tension, or dissonance. Dissonance has been a recurring theme in the literature to describe the cognitive gap that nursing students experience between the pre-held, idealistic views of the nursing role with the realities experienced in practice (Kramer, 1974; Grafton et al., 2010; O’Donnell, 2011). This mismatch in expectations is a primary source of adversity and is especially true when transitioning into task-orientated environments where holistic models of care compete with business models that focus on efficiency. Nursing students struggle to balance two seemingly opposing philosophies of care and it becomes a source of tension (Day et al., 2005; St.Pierre and Holmes, 2008). Another significant source of adversity is workplace violence. It may manifest as the unfair treatment of nursing students or, as students witnessing violations of patients’ rights (Thomas and Burke, 2009). Violence and rights violations are also a source of attrition because these acts can lead to an erosion of professional communication and teamwork whereby clinicians lose a sense of commitment to their work (Vessey et al., 2010).

To date, much of the research literature had focused on structural causes of adversity such as policies, systems and hospital hierarchies (St.Pierre, 2012; Ulrich et
al., 2005). However, an important change in research focus highlighted that some sources of adversity are culturally located – that is, nurses often feel oppressed by discourses and behaviours that convey the dominant values and ideologies of others (Laschinger et al., 2012; Levett-Jones and Lathlean, 2009; Murphy, 2012; Thomas, 2012, Jackson et al., 2011). Critical perspectives that focus on the experience of adversity as hierarchical power imbalances are also evident in the literature. These views reveal that oppressive workplace cultures are especially distressing to nursing students (Evans and Kelly, 2004; Pearcey and Elliott, 2004; Peter et al., 2004; Kelly and Ahern, 2008; Lumby, 2008; Thomas and Burke, 2009).

The review of the literature revealed numerous factors that culminate in adversity for nursing students on clinical placement. However, no papers have reported on how such experiences of adversity might be transformed to become opportunities for vicarious learning for others. Thus a study was designed to privilege the student perspective on adversity and for students to collaborate on the production of lesson plans based on their experiences.

**STUDY**

*Study aims*

The aims of the study were to (i) understand the ways that nursing students experience adversity on clinical placement and, (ii) to partner with them to explore culturally-based solutions that may equip future nurses to be more prepared and less vulnerable to stressors that could otherwise be harmful to them. Ethical approval for the study was obtained from the relevant university ethics committees prior to undertaking recruitment. Pseudonyms were used to ensure participant anonymity in the presentation of study data, and are used in this paper.
**Recruitment**

The research was undertaken at a medium sized, regional university in South-east Queensland, Australia, between 2013 and 2015. Students were enrolled in years one to three of the undergraduate Bachelor of Nursing Science degree. Recruitment was via a flyer emailed to a target population on the university’s intranet site. Students who expressed an interest in the study were emailed a copy of the research participant information sheet and consent form and advised that they might ask any questions about their involvement prior to signing consent on the day of the interviews.

**Data collection**

Interviews were carried out in two stages: the first stage involved individual guided interviews with nursing student participants using a critical incident questionnaire. The interviews resulted in 12 critical events embedded within the stories of adversity. These stories were converted to condensed narratives by the researcher to illuminate the important messages that were being conveyed. The second stage involved individual guided interviews where nursing student participants were recalled. Six of the 12 narratives were chosen as stimulus material to assist participants to reflect on the events and critique them for the messages they thought were being conveyed. In addition, participants were asked how they would teach these important lessons to future nursing students in the current nursing curriculum.

**Data management and analysis**
Critical Discourse Analysis (CDA) was used to analyse the data (Fairclough, 2010). This approach is concerned with the way in which knowledge, power, culture and social structures are represented in everyday practices, discourse and texts such as the student stories of adversity (Crotty, 1998). Data analysis involved deconstructing texts and discourses in order to reveal the discursive elements such as power relationships and conflicts. Analysis of the stage one data began with Street and Kissane’s (2001) strategy to breakdown discursive structures and involved looking for alternative interpretations in the discourses; searching for other dimensions that may have contributed to the construct of adversity; acknowledging that the practices under scrutiny were context-specific and, looking for how practices sustain power relations.

The narratives were synthesised and tabulated to provide an overview of the core discourses from the critical incident questions. Recurrent, dominant and contradictory discourses were identified and selected for further in-depth analysis so that everyday taken-for-granted beliefs, values and norms inherent in speech acts and normative practices could be organised and subject to critical evaluation. Then, Fairclough’s (2010) CDA framework was chosen to critique the identified discursive structures. The CDA framework provided a stratified model for examining the core discourses on 3 levels: Macro, Meso and Micro. Macro involved linking the language to the dominant sociocultural ideologies influencing the discourse; meso involved uncovering how historical and social nursing conventions are represented in the discourses so that certain ideologies are privileged over others and, micro involved deconstructing stories, and verbal/non-verbal interactions. In order to understand how a nursing student makes the decision to remain passive and acquiescent in the face of hostile behaviour, it requires the examination of discourses about conflicting ideologies on the role and status of nursing students on clinical placement. A pervasive view of nursing students as
part of a transient workforce with a different mindset and minimal hands-on skill may 
emerge as one reason for students accepting their oppressive treatment and exclusion 
from team processes as “part of the job”. CDA helped to explore how prevalent health 
care culture informed the personal accounts of the participants.

FINDINGS

Participants included seven female undergraduate nursing students, aged between 34-56 
years. Six were domestic students and one was an international student.

Critical Discourse Analysis

Four key discourses were selected for in-depth analysis because they were 
prominent and recurring in the data set, and identified in previous research but not 
explored for their contradictions, inconsistencies or alternative interpretations. These 
have been entitled: power relationships are a two-way street; learn from mistakes to 
prevent mistakes; begin cultural consciousness-raising in first year, first semester; and 
become critically self-aware.

Power relationships are a two-way street

One of the study participants, referred to as Sandy, explained in detail something 
that other students strongly related to – that often students’ own previous knowledge 
and experience is discounted on clinical placement, and only the registered nurse’s 
experience is valued. Yet the student argued, that all people in relationships have power, 
even if one person’s power might be sourced from personal and not professional
experience. It is important for students to learn how to value their own power, and the power of others with whom they relate.

The mature-aged student reported a story in which she assessed an elderly man as being confused when she had found him to be fully orientated the day before. In response to her concerns, the student observed that the registered nurse assessed the client using closed questions and concluded that he was fine:

And I kind of said, “No” – I did try to push a bit more and I said, you know, “He just doesn’t seem right and he’s a bit confused.” And eventually, she agreed to… mention it to the medical officer, but she mentioned it in a way that I felt made it look like it was an insignificant thing. It seemed like she didn’t give the value to it that there was a change in him…Yeah, I felt like it had been fobbed off

(Sandy)

Such an experience is common within professional cultures, and is described by hooks (1994) as the hegemony of the authority of experience. That is, only knowledge from those with a substantial work history is valued. Naivety is dismissed. From this viewpoint, the experienced nurse has authority over students even though novice nurses might have significant life experience and see the nursing world through fresh eyes.

Being ‘fobbed off’ is one way students can be silenced, for experiences to become adverse, for this to lead to their ongoing silence, and thus for a vicious cycle to be created. Another participant presented a similar example of self-silencing behaviour:

sometimes you just need to grin and bear it, but it’s ethically wrong, especially if you’re hurting someone or you’re not doing something safe (Jenny)
These quotes reveal a point of tension which impacts greatly on the day-to-day working experiences of nursing students and in how they fulfill their goals and learning potential. A curricula response would not be to dwell on the power imbalance that has been created between the student and the registered nurse, but to develop students’ communication skills that enable them to tactfully speak up at opportune times in order to forge a connection with their professional colleagues, and thus to interrupt any risk of stress leading to adversity that leads to silence and disengagement.

In one story, a mature aged student had an experience where she was publicly criticised for her time-management by an enrolled nurse with whom she was working. Although shocked and disheartened by the incident, after revealing the story in the process of this study, the participant later began to read about bullying and violence in the workplace and realised that this was what she had experienced. Rather than feeling victimised, the student felt empowered by this new knowledge and designed a poster on the topic. The student went on to present the poster at nursing conferences and local workshops. Her conclusion was to suggest that power relations do not only work in one direction, and that people are free to resist without always being aware that this is the case.

At that time I thought that power was a one-way street, but it’s not (Mary)

This insight is an important one for all nursing students to understand, so that they realise they have part to play in transforming interpersonal relationships. She explained that bullying can be a learned behaviour and requires learning to respond constructively.
Gaining this new knowledge enabled her to perceive the registered nurse differently, and with more empathy:

This registered nurse is obviously entrenched in the ways as to how to treat nursing students because she was probably treated that same way herself. And I thought ‘bingo’! (Mary)

**Learn from mistakes to prevent mistakes**

Another dominant discourse in the interviews was the challenge of students learning to think about vicarious experiences of adversity in order to think through ways of responding. Participants felt that sharing these experiences with other students in the form of narratives could become a powerful prevention strategy to help them to function effectively in the face of adversity:

If we started talking about it [adversity] early on in the piece, and did maybe something every semester on resilience, or bullying, or aggression minimisation…then I think… if it did happen to you, then you would understand more what to do (Lisa)

In another story, an already experienced enrolled nurse recalled how troubled she was that invasive procedures continued to be suggested as treatment options to the family of a patient with advanced metastastic disease whilst palliation was not. During the interview for this study, the reflective process prompted the participant to recall how she had been angered by a film portrayal of incomplete disclosure of treatment options to a patient with cancer. She realised that this was the troubling issue that she had just
experienced. The participant explained that being perceived as subordinate within a hierarchical structure can be a source of distress. Her perception of her status as lower than that of the registered nurse and doctor was sufficient enough to hold her back from speaking out against seemingly futile interventional approaches to care in dying patients:

I don’t try to get above myself in that respect. I am an EN on the ward. I’m under the umbrella of a registered nurse, so I don’t feel that’s my place to really say too much. Do you go to the registrar and say, “When are you going to stop? This is too much intervention for this patient.” There’s a hierarchy still in nursing (Annette)

The participant reasoned that being able to respectfully contribute to the decision-making process was a skill that could be learned and that sharing original narratives of nursing students could make a significant contribution to this learning.

The value of vicarious learning is that nursing students can take on board important lessons from their observation of their peers and it is especially powerful if they are able to relate to the behaviour that is being modeled (Bandura, 1977). In the case of nursing students observing experiences of adversity, when their peers are their role models, they may be more able to picture themselves in a comparable situation and responding in a similar way.

Begin cultural consciousness-raising in first year, first semester
Participants were unanimous that awareness of culturally based experiences of adversity should to be shared with students very early in their nursing programme in first year, first semester, before placement and repeated in most subjects every semester:

It would have been so good to have that insight or that information before I went out on that clinical placement, that’s why I’m feeling, in first year, these sorts of little bits of information are so important to students (Mary)

One participant had reservations that adversity narratives could frighten nursing students, however, others felt that the narratives could be empowering if they were used to raise awareness of what to expect and discussed in conjunction with a “tool kit” on how to deal with continued difficulties, as illustrated in the comment below:

I think it all depends on personality, because some people just get really scared of things and if you tell them more, they get more scared maybe…it’s not for everyone. But for me, I probably would like to know it beforehand so I might face this kind of situation (Joan)

A key insight for educators in this comment is that educators need to be courageous and skilled in drawing on adversity narratives effectively, so that students grow through engagement with the stories, and are not inadvertently upset.

*Become critically self-aware*

Student participants felt that an important lesson about adversity is to learn how to respond if and when it occurs, and to have the skills to respond effectively, giving
feedback about how communication or events might be handled differently, and less adversely in the future. In this way, students could feel more effective as change agents. In this example, a participant revealed the guilt that she felt at being unable to speak up to advocate for a client when witnessing a senior clinician perform suture removal that contaminated the wound and caused the young client to faint. The example illustrates the complex effects of adversity – it can harm multiple people and can lead to negative emotions that recur beyond the immediate event:

One young boy had a big 20cm long incision. It was one long continuous suture. And I was watching – because this was the first one – and the nurse had cut the knot at the end and then cut every third one, and then proceeded to pull. So she’s pulled three big loops under the skin and out, but the pain that that must have been causing, the young boy passed out. And I’m thinking, number one, you’re pulling dirty stuff back through clean skin, Number two, you’ve just caused him so much pain he’s passed out. So I didn’t say anything because I knew she was the head of the area (Jenny)

The participant said that this story could be shared with other nursing students to help them learn about the complex impacts of adversity and to consider what, how and when to give feedback to someone who you believe could or should moderate their behaviour. Including this story, and prompts for students to consider alternative responses, would develop communication skills needed to approach adversity constructively, rather than react emotionally.

AN EDUCATIONAL APPLICATION OF THE FINDINGS
Participants were eager to see that their experiences of adversity could be put to more productive use in the future. They saw merit in reframing their critical incidents into narratives that could be used as stimulus material for other students, for these narratives to be scrutinised, and strategies developed and shared so that the situation could be transformed and not lead to outcomes that were harmful to them. Generating learning experiences through narratives was seen as a way to awaken students to realities ahead, and sensitise them to the need for skills other than those that are technical or procedural. Through the course of this study, these experiences were converted into narratives and embedded in lesson plans.

A narrative-based lesson plan

An example of one of the lesson plans that addresses the need to ‘learn from mistakes to prevent mistakes’ is presented here. In this story, a nursing student had an experience where she was asked to check an opiate with a male clinical nurse. She had noticed that he was often in charge of the shift and did not really think that he might make a mistake, and because she had found him to be easily annoyed and dismissive at times, she was mostly concerned with not getting on the wrong side of him. She was also unaware of his reputation for not following procedure when checking and dispensing controlled drugs. He tended to conceal what he was doing and failed to count the drug stock correctly:

I’d been on the ward probably two or three weeks. 5 milligrams of morphine was to be given to a female patient, a very thin, small, female patient. I went into the drug room with the CN on duty. He was a very experienced CN who
had been a nurse since he was 18 and he’s in his middle 30s. Got the medication out of the S8 cupboard drew up the vial. He turned his back. I never saw the vial, I never saw the count. I signed off on it and went to the bedside, did the rights, very professional of us, gave the medication to the lady, walked away. Within probably half an hour to an hour, some sort of count was done. It was quickly realised that 10 milligrams instead of 5 milligrams had been given, and guess what? I’d signed off without seeing a thing (Annette)

In considering how this narrative could be used in the curriculum, one participant proposed that real life stories have value because students can learn about the repercussions of their actions. The participant felt students should know that they could lose their registration, or that a patient could die if they do the wrong thing. The participant suggested that debates are essential in preparing nursing students for the workplace. As a formal discussion that involves the presentation of opposing viewpoints, she felt that this mode of learning could help to build advocacy skills because students are required to deliver arguments in a non-confrontational way. The participant suggested that the topic should be challenging and thought provoking. She was particularly keen to see debates that were contextualised to nursing issues and recommended this title as follows: “Is it acceptable to avoid someone that is perceived to be a bully in the workplace”.

The debate - “Should the student confront or avoid her colleague?”

Learning outcomes - students will be able to:

1. Critically evaluate the impact of this incident on the people involved
2. Deliver a reasoned argument in a non-confrontational way
3. Contribute effectively as a team member in support of the stance taken on the issue and to respond to counter arguments

4. Apply principles of critical thinking to discuss strategies that help to ‘find one’s voice’ so that nurses might develop a sense of agency

Activity

Educators will discuss the principles of critical thinking prior to the debate. Facione (1990) defines critical thinking as purposeful, reflective, self-regulatory judgment and the characteristics of a critical thinker will be discussed. Prior to students reading the story, the educator provides some background context by explaining that this was a true story that happened to a past student, where and when it took place, and who else was involved. Preparation for the debate involves reading Annette’s story about a drug error, and considering the following question, “Is it acceptable to avoid someone that is perceived to be a bully in the workplace?” In class, students will use prepared notes to enter into a debate with colleagues providing a reasoned argument for the stance taken on this issue.

DISCUSSION AND RECOMMENDATIONS

This study found that nursing students experience adversity in many ways, and they feel disempowered and vulnerable because they are not prepared for this reality. This finding has been reported in many other studies (Curtis et al., 2007; Grafton et al., 2010; Hoel et al., 2007; Kelly and Ahern, 2008; Pearcey and Draper, 2008). Students are often targets of, or witnesses to, violence, exclusion and the delivery of morally constrained care (Chiarella, 2007; Hegney et al., 2010; De Chesnay and Anderson,
2012; Vessey et al., 2010). It is evident that frequently, these stressors result from dominant and prevailing cultural forces (Laschinger et al., 2012; Levett-Jones and Lathlean, 2009; Lumby, 2008; Murphy, 2012; Thomas, 2012, Jackson et al., 2011).

One significant finding in this study is that the process of assisting participants to engage in critical reflection on adverse events resulted in raised awareness of the phenomenon of workplace violence and motivation to find solutions independently. The responses suggest that adversity does not need to be cyclical and reproduced through generations of nurses, it can be interrupted when students develop self-efficacy, group cohesion and use strategic action, and this supports the findings of Jackson et al. (2011).

Furthermore, learning that extends thinking capacity can help students to notice dominant culture and critically reflect on how prevailing ideologies perpetuate the status quo. In doing so, students are prompted to carefully consider how cultural norms impact on care delivery (Croft and Cash, 2012; Duffy et al., 2012; Saltzberg, 2011).

Preparation for clinical practice involves a combination of technical, procedural, interpersonal and critical thinking skills. Learning activities designed to promote understanding of health care culture and practice contexts appear to have been either absent or ineffective for participants in this study. Some participants revealed a resolve to be silent or acquiescent in the face of adversity for fear of isolation, reprisals or not knowing what to say and how to say it (Holmes et al., 2012; Levett-Jones and Lathlean, 2009; Youngson, 2011). Others already seemed socialised to accept hostile behaviours as inherent in nursing work (Mackintosh, 2006; Price, 2009).

The main recommendation in this paper to mitigate against culturally driven hostilities in future is to empower students so that they know more about what adversity looks like, how it can stem from nurse-nurse conflict and, that students can learn thoughtful and strategic responses so that they can reframe the stressors and not
internalise them. A growing body of work acknowledges that mental health and well-being is greater in people who have experienced previous adversity than those who have not (Seery, 2011). Capacities for positive adaptation to adversity can be enhanced when people are assisted to tap into their own resources, engage in social networks and develop a sense of mastery for future events (Seery, 2011). Accordingly, an emancipatory teaching model is proposed that extends the focus of developing technical competencies that are the ‘doing’ skills of nursing, towards skills that are values based, communicative and emancipatory. In the model (see Figure 1) critical thinking can also address the need to cultivate a realistic world-view amongst nursing students, referred to as ‘realising’ in the model. It follows that nursing students then develop a sense of mastery in critiquing practice through critical reflection, referred to as ‘critiquing’ in the model.

**Figure 1**

An emancipatory teaching model.
Developing a realistic world-view and the capacity to critique practice through critical reflection could help nursing students to reframe adverse events in terms of their cultural origins and move beyond a focus on the inflexibility of rigid institutional structures to encompass actions possible through individual agency. Visioning is the final step of the model because in the traditions of critical inquiry, it is not sufficient to deconstruct the issues of today without harnessing a vision for the future. This is a crucial step in turning critical thought into critical action. However, further critical analysis of this narrative-based approach is recommended to enable a robust application of the model in preparation for practice programs. Ongoing evaluations of the model and lesson plans offer future research opportunities.

LIMITATIONS

One of the limitations of this study is the small number of participants who were all female, from one university and in one state of Australia. Further research could include male students, a wider age range, and a multisite approach across Australia to provide greater generalisability and strengthen the proposed outcomes. However this study highlighted the impact rather than the extent of the problem of adversity for nursing students and reveals the value of narratives that embody important cultural lessons for future students.

CONCLUSION

The nursing curriculum is designed to prepare nursing students for future practice roles but the perpetuation of inhospitable health care cultures means that many
students entering the workplace are prevented from reaching their full learning potential. Critical thinking is becoming an important feature of contemporary nurse education and this study provides a critical teaching framework that educators in undergraduate education may use to focus attention on developing high level thinking skills and individual agency in nursing students. This study has highlighted that learning challenges prior to practice are important in empowering students to deal with workplace adversity. The timely exploration of educational solutions that promote individual agency have the potential to create opportunities for sociocultural change by nursing students entering the system rather than from top-down institutional change. Nurse educators, new graduates and nursing students seeking to reform health workplaces so that they move beyond adversity and focus on well being and connectedness could take up such an approach.

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