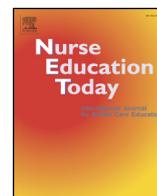




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Patient safety in nursing education: Contexts, tensions and feeling safe to learn

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SUMMARY

Education is crucial to how nurses practice, talk and write about keeping patients safe. The aim of this multisite study was to explore the formal and informal ways the pre-registration medical, nursing, pharmacy and physiotherapy students learn about patient safety. This paper focuses on findings from nursing.

A multi-method design underpinned by the concept of knowledge contexts and illuminative evaluation was employed. Scoping of nursing curricula from four UK university programmes was followed by in-depth case studies of two programmes.

Scoping involved analysing curriculum documents and interviews with 8 programme leaders. Case-study data collection included focus groups (24 students, 12 qualified nurses, 6 service users); practice placement observation (4 episodes = 19 hrs) and interviews (4 Health Service managers).

Within academic contexts patient safety was not visible as a curricular theme: programme leaders struggled to define it and some felt labelling to be problematic. Litigation and the risk of losing authorisation to practise were drivers to update safety in the programmes. Students reported being taught idealised skills in university with an emphasis on 'what not to do'.

In organisational contexts patient safety was conceptualised as a complicated problem, addressed via strategies, systems and procedures. A tension emerged between creating a 'no blame' culture and performance management. Few formal mechanisms appeared to exist for students to learn about organisational systems and procedures.

In practice, students learnt by observing staff who acted as variable role models; challenging practice was problematic, since they needed to 'fit in' and mentors were viewed as deciding whether they passed or failed their placements. The study highlights tensions both between and across contexts, which link to formal and informal patient safety education and impact negatively on students' feelings of emotional safety in their learning.

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Introduction

Improving patient safety is a global concern. In 2001 the UK National Patient Safety Agency (NPSA) was established followed by the World Alliance for Patient Safety in 2004 (WHO, 2004). However UK inquiries continue to highlight safety issues; children's heart surgery at Bristol (Kennedy, 2001); the Maidstone and Tonbridge Wells investigation into *Clostridium difficile* (Healthcare Commission, 2007); and the recent inquiry into care provided by Mid Staffordshire National Health Service (NHS) Foundation Trust (Francis, 2013; Hornett, 2012). Issues included:

teamwork, workplace culture, leadership, communication, staffing levels, training, difficulties in reporting concerns; and information monitoring. The increased profile of patient safety resulted in numerous campaigns and collaborations across UK universities, the NHS and beyond (Slater et al., 2012; Burston et al., 2011). Developments include the Safer Patients' Initiative (Health Foundation, 2011a), Scottish patient safety programme and research network (Haraden and Leitch, 2011), and patient safety research centres. Thus considerable research and development have been stimulated in areas including, adverse events (Jordan, 2011), medication issues (Wulff et al., 2011), non-technical skills (Gordon et al., 2012; White, 2012), organisational factors (Dodds and Kodate, 2011) and human factors (WHO, 2009). Despite some progress, unnecessary patient harm remains a key issue for nursing and health care (Health foundation, 2011b; Jordan, 2011). Education is recognised as playing a major role in developing safe, high quality, nursing and health care (Francis, 2013; Mansour, 2012; Slater et al., 2012; Pearson and Steven, 2009). However a recent review of evidence on perceptions of patient safety in pre-registration and

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undergraduate education revealed a continued lack of research and the need for 'patient-safety-friendly nursing curricula' (Mansour, 2012, p.536).

Background

In 1994 Leape argued the most fundamental change needed if health care was to make meaningful progress in error reduction was cultural. Progress was seen to lie in addressing underlying conceptual models of, and attitudes towards, error, and in the establishment of learning cultures that enable systematic error reporting and continuous practice improvement (Lester and Tritter, 2001).

In 2004 the NPSA placed education at the centre of their *Seven Steps to Patient Safety* document (National Patient Safety Agency, 2004). In 2006 the Department of Health (DoH, 2006) suggested education providers ensure advances in healthcare education and training to support patient safety, highlighting the need for a patient safety curriculum promoting appropriate attitudes, behaviours and skills. Milligan (2007) argued that shifting UK healthcare towards a patient safety culture required changes to healthcare professional education and training. However concern was expressed regarding a focus on individual errors in nurse education (Gregory et al., 2007) with claims that nursing curricular competencies urgently needed changing to match the needs of the practice environment (Sherwood and Drenkard, 2007). Thus the place of learning, education and training in promoting and supporting a safety culture has long been recognised (Pearson et al., 2010; Sammer et al., 2010).

In 2009 the WHO produced a patient safety curriculum for medical schools, and a multi-professional edition in 2011. Howard (2010) and Gantt and Webb-Corbett (2010) describe educational frameworks for learning and teaching about patient safety, yet it is unclear how much behaviour is driven by hidden curriculum or practice culture (Bradley et al., 2011), or which educational strategies are effective in creating change. A strong evidence base does not yet exist about how patient safety is understood and applied during training, or ways that it can be effectively incorporated in health care curricula (Mansour, 2012; Pearson and Steven, 2009; Attree et al., 2008). Few studies systematically explore patient safety in pre-registration nursing (Mansour, 2012). At a time of transition this is a critical area for investigation.

Aim

The study from which the findings of this paper are drawn aimed to investigate the formal and informal ways pre-qualification students from a range of healthcare professions learn about keeping patients safe from errors, mishaps and other adverse events. Findings from the nursing programmes are presented while other findings are reported elsewhere (Pearson and Steven, 2009).

Methods

Design

The methodological approach drew on 'illuminative evaluation' (Parlett and Hamilton, 1977) which focuses on exploring, describing and interpreting. A two stage theoretically based design was employed (see Fig. 1) underpinned by Eraut's theoretical framework (Eraut, 1994, 2000) which suggests that we learn from (i) formal planned education (undertaken in university or college); and (ii) informal education (in all settings) which includes common ideas, ways of thinking, traditions, and beliefs that are unwritten but form a part of our daily life. Stewart (2008) re-conceptualised Eraut's work into three knowledge contexts (Fig. 2), which formed the basis of the study design (Fig. 1).

Ethics

Ethical approval was granted by the Local National Health Service Research Ethics Committee. Site-specific approval was obtained at each site and from university committees. Ethical issues included: potentially 'discovering' threats to patients' safety (none emerged), power dynamics (between researchers/practice staff/students) and anxiety regarding the 'safety' focus of the study. Protocols were implemented to deal with potential safety issues; informed consent was obtained; researchers stressed throughout that no judgements of educational or clinical practice were being made and that decisions regarding participation would not affect future education or employment.

Data Collection and Participants

Data were collected between 2006 and 2008. Stage one explored the formal curricula of four pre-registration degree level nursing programmes in four UK universities (Table 1). Programme documents were collected (Table 2) and analysed alongside semi-structured interviews with programme leaders/equivalents ($n = 8$). To enhance transferability a range of programmes were included (Table 1). Variations included programmes based in England and Scotland (different policy contexts and health care systems), differing university histories, geographical locations and course characteristics.

Documents were analysed for how patient safety was represented in curricula, the programmes' formal intentions, and to develop an understanding of 'education as planned'. Interviews examined programme information, identified where participants felt patient safety lay within the curriculum and obtained views about how or what patient safety education is or should be. Two programmes employing diverse curricula in different types of university, and located in differing geographical areas were selected for in-depth case study in stage 2 (Stake, 1995). Three teaching sessions (each up to 3 hrs) were observed for each programme. Researchers used an agreed observation framework covering: implicit and explicit content; verbal comments; staff and student behaviours; and explicit and implicit messages regarding patient safety. Observations of clinical areas (four episodes/19 hrs) during student placements obtained snapshots of practice culture and influences on students.

Focus groups (FG) were held with second and final year students ($n = 24$), newly qualified nurses ($n = 4$), practice staff who taught or supervised students ($n = 8$) and service users involved in curriculum development or delivery ($n = 6$). Interviews were undertaken with nurse and risk managers ($n = 4$) in NHS trusts providing student placements. Interviews covered the organisation's views of, and approach to patient safety, links with education and organisational ethos/culture.

Documents concerning patient safety, i.e. policies and protocols ($n = 9$) were also requested. Analysis aimed to provide an overview of the organisations' formal approach to patient safety, and develop an understanding of their ethos.

Analysis and Rigour

The team developed analytic frameworks and coding. Documents were content analysed, interviews and focus groups analysed via a thematic approach and observations condensed using vignettes. Topics important to participants, and unanticipated themes were allowed to emerge. Findings from one research stage informed the next. Two researchers analysed data independently and then compared findings. After completion of the project the authors continued to refine the analysis during the writing process and conference presentations.

Findings

The findings are presented by context and theme, and draw on all nursing data sets, integrating results of the scoping exercise (stage 1) and case studies (stage 2).

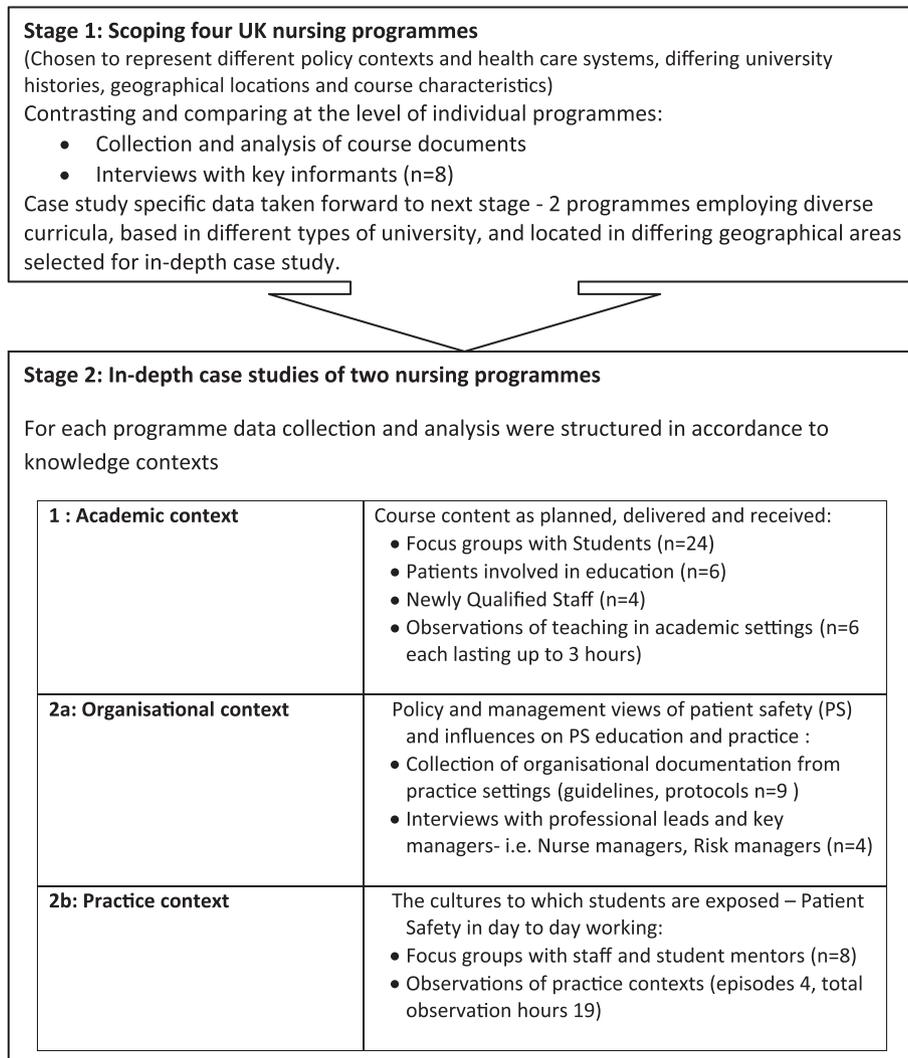


Fig. 1. Study design.

The Academic Context: Visibility of Patient Safety

In curriculum documents examined in stage 1, patient safety was not visible as a separate theme, but as a series of statements about

safety. For example in University A, one of the Year 2 learning objectives stated the student should be able to demonstrate, 'safe, effective and evidence based practice responsive to the needs of patient/client groups'. At University B, the curriculum described a variety of safe

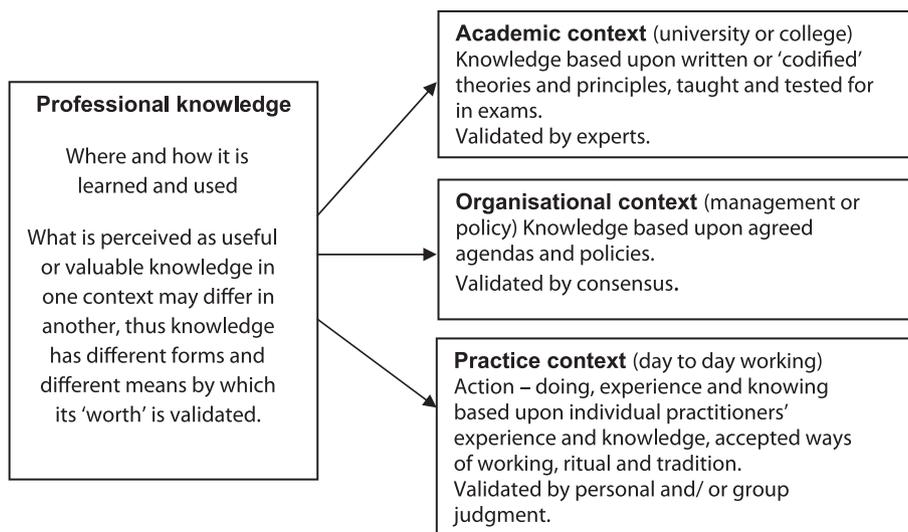


Fig. 2. Knowledge contexts: Re-conceptualisation of Eraut's work after Stewart (2008).

Table 1
Details of courses sampled.

Site	Type of university	Commonalities	Differences
A	Old established university	<ul style="list-style-type: none"> All four programmes degree level, Three years in length, 50% theory and 50% practice Validated by UK Nursing and Midwifery Council (NMC). 	<ul style="list-style-type: none"> Schools of nursing established at different points in time. The courses examined had been running for different lengths of time Differing numbers of students enrolled
B	'Post-1992' university		
D	1960s university		
E	Established as a university in 1960s, previously a further education provider		

practices: 'maintaining safe practice – moving and handling; preventing the spread of infection, hand washing, safe use and disposal of equipment, safe storage and administration of drugs'.

The lack of visibility of the term 'patient safety' in curriculum documents was echoed in interviews with programme directors who struggled to define it as a discrete concept:

'it's not just one thing with patient safety it goes right the way through the system, from making sure it's the right patient with the right drug to how they're lifted, fed, everything'.

[(Site D, Programme leader)]

There was a perception that patient safety should be embedded throughout educational programmes. In general respondents did not support specific modules labelled as 'Patient Safety':

... I design a module and I call it patient safety – the students would think that every other module had nothing do with patient safety. You've boxed it into that box. So in that way if you do badge it what you're doing is you [are] almost ghettoising it.

[(Site B, Programme leader)]

Students mentioned the ways patient safety was threaded throughout their education linking it to patient centred care.

Practice staff expressed a holistic view of patient safety which was patient focused and embedded across all nursing care:

I think of patient safety as principally being that anything you do with them they won't experience any harm from... That you'll actually help them.

[(Site E, Practice Staff FG)]

When someone says..'patient safety' I would think of making sure your patient doesn't come to any harm in any way – whether that's physical harm or emotional.

[(Site B, Final year student FG)]

Newly qualified staff however could 'recall very little in terms of training specifically about patient safety' concluding that:

'It's a very broad subject, it's quite hard to actually physically talk to someone about it but I think you learn about it as you go along'.

[(Site E, Newly Qualified Staff FG)]

These accounts suggested a tension existed between a perceived need to make patient safety visible in formal curricula and a strong feeling that it should be embedded throughout practice ('you learn it as you go along') and not taught as a discrete topic.

Curriculum documents from all sites emphasised producing safe practitioners following UK Nursing and Midwifery Council (NMC) guidance. Interviewees indicated that regulatory bodies, professional bodies and quality assurance agencies had a major influence on patient safety within nursing education:

From the very beginning when I teach about professional standards and professionalism and clinical governance, it's all in there because it has to be, because it's driven by our professional code.

[(Site A, Programme leader)]

Litigation and the risk of losing authorisation to practise were seen as drivers for updating safety education. A sense of responsibility to keep students emotionally safe in their learning and practice also emerged. It was felt necessary to 'package' patient safety education to ensure students were not frightened about making mistakes. However students noted that lecturers emphasised caution and a 'what not to do' approach, which they viewed as motivated by patient safety, legal and professional reasons:

Patient safety is also about protecting nurses... if you protect your patients, the staff are protected as well, from, the blame culture... And litigation... another reason why patient safety's such a big thing.., because the patients are more aware ...and if you make a mistake they're more aware of their rights.

[(Site B, Final year student FG)]

Students reported an academic emphasis on caution with regard to their own knowledge and skills:

We're being told over and over again don't do something you don't know how to do... that's kind of patient safety in a way... don't put the patient at risk.

[(Site B, 2nd year student FG)]

Such an emphasis portrays patient safety as predominantly related to risks of practice, independent of practice type, and has the potential to lower self-confidence and encourage students to become tentative in their practice. Thus students expressed a tension between

Table 2
Curriculum documents gathered.

Programme	Document types		
	Programme wide documents	Handbooks	Other documents
Nursing A	Programme specification, Course description, Course overviews	Overall programme handbook Course handbooks	Student recruitment and admissions info sheet
Nursing B	Programme specification	Module handbooks	Learning and teaching strategy
Nursing D	Validation documents	Student handbooks	Concept maps
Nursing E	Validation documents	Module handbooks Student handbook	

perceived 'risks' to patients and the need to practise defensively set against the need to 'try out' and practise skills.

The Organisational Context: Systems and Learning

Risk and Nurse Managers conceptualised patient safety as a complicated problem which could be broken down into parts and dealt with via organisational systems, procedures and guidelines:

We've been developing and progressing systems in the patient safety arena constantly.

[(Site, E Risk manager)]

However, framing patient safety as distinct from staff safety was questioned by some:

We talk about safety generally, because if you have an unsafe situation for your clinical staff, it is inevitably going to rebound on patient safety.

[(Site B, Risk manager)]

Training was viewed as an important mechanism by which newly qualified staff learnt about policies, procedures and systems. However there were few formal mechanisms for students to learn about organisational strategies and systems and this was often ad hoc and down to mentors:

First year placement I think we had a policy day, like fire drill and policies like that.... on the ward you get told where the fire exits are, where this is, where that is. And that's really it.

[(Site B, 2nd year student FG)]

Likewise formal mechanisms for information flowing from universities to health Trusts regarding curricula were unclear:

We've just stopped student nurses having anything to do with blood transfusion... We realised they had absolutely no training.

[(Site E, Nurse Manager)]

Learning from incidents, underpinned by the risk assessment strategy and supported by training was seen as key:

Years ago there was a shame and blame culture... you are actually getting more... from learning from the incident than you are from shooting somebody.

[(Site B, Nurse Manager)]

However, the vision of an organisation where staff felt safe to report remained challenging. Tensions existed between an open culture of reporting and learning, and mechanisms for identifying and addressing under-performance:

you can do all these audits and all these risk assessments, but they need to be collated and presented...to make sure that everyone has a reporting mechanism for viewing this data. So it's open and transparent and we can do something about it [poor performance] if we need.

[(Site E Manager 2)]

In both sites the move to a culture of learning from incidents was viewed as problematic in term of report making and feedback to staff:

It is easier to feed up than down....

[(Site B, Manager)]

Given that the organisational context forms part of the 'practice learning milieu' (Parlett and Hamilton, 1977) in which students

spend 50% of their education, such tensions have implications for placement learning.

The Practice Context: Role Models and Practice Culture

Practice learning mainly took place by observing qualified staff who varied as role models. Students and newly qualified nurses had to contend with the harsh reality of the practice culture and the positional power of those further up the hierarchy:

You do your best to put theory into practice... but if you've got a Sister who's telling you not to do that then you know it's an impossible situation.

[(Site B, Newly Qualified Staff FG)]

You go into a cubicle with another nurse and the patient wants moved up the bed..the nurse looks at you and says: 'are you alright to do this move'? ...you know they're going to slide them up on the sheets but you know if you say 'no I'm not going to' they're gonna be nasty about you behind your back'.

[(Site B, 2nd year nursing student)]

Students reported skills taught in university were idealised and removed from practice reality. This was compounded by feeling guilty that they distracted staff from patient care. Factors potentially impacting on these feelings and on student learning, included inadequate staff numbers for the workload, equipment availability and patient factors. Relationships between students and clinical mentors were a crucial influence on learning, but varied:

It's a close relationship... you get to know what they're [the student] capable of ... if you didn't have that bond..then there's not trust.

[(Site B, Staff FG)]

It [practice education] varies so much from ward to ward depending on where you are and who your mentor is – whether your mentor's very motivated to actually teach you.

[(Site B, Final year student FG)]

Students were aware of power imbalances: mentors assessed student practice and thus passing or failing a clinical placement was in their hands:

[re challenging practice] I would never say anything because you'd just jeopardise your career and get a name for yourself... you're too scared to say anything and mentors... grade you.

[(Site B, Final year student FG)]

Feeling safe to report errors, challenge practice or put theory into practice appeared problematic with the need to 'fit in' also impacting on patient safety learning:

How do you challenge [unsafe practice] without becoming unpopular? You're only there for 8 weeks, we've got to be careful... We're only student nurses ...there's university saying 'you're supposed to be challenging'. But you think to yourself: 'hold on a minute! Not qualified yet, me a mere student – not getting paid for doing that'...

[(Site B, Final year student FG)]

I would never do something if I knew it would be unsafe for me or the person I was doing it on, but I still don't think I would be able to question the sister on the ward....

[(Site E, Final year student FG)]

In contrast some students suggested that they needed training on resisting dominant views that contradicted theory, and support and leadership to implement safe practice:

A lot could have been done on assertiveness, because as a student nurse you are influenced a lot by the more senior members of staff. [Site B, Newly Qualified Staff FG]

Thus an emotional dimension to learning emerged which related to applying a 'by the book' version of nursing work into the reality of complex clinical practice (Steven, 2009), maintaining relationships with mentors, and managing emotions in order to be accepted into the ward culture.

Discussion

Findings demonstrate that tensions exist between and across academic, organisational and practice contexts, with implications for patient safety. The label 'patient safety' was relatively invisible in written curricula, except for mentions of components such as hand washing or infection control. This may highlight the limitations of curricula documents as data given they are generally produced for programme 'validation' and only open to minor changes thereafter. Thus documents neither reflect subsequent developments nor the reality of programme delivery. Cognizant of these limitations, interviews with programme leaders were also included in the study design to gather contemporary perspectives.

Programme leaders, clinical nursing staff and students all viewed patient safety as a concept underpinning practice – akin to holism and person-centred care (Dossey and Keegan, 2009). Programme leaders struggled to define patient safety as a discrete concept and some were concerned that labelling parts of curricula, although potentially raising awareness, may lead to students feeling they had covered 'patient safety'. Apprehension regarding labelling may also reflect unease with a 'compartmental' approach to professional education which moves away from an immersion in practice model (Lave and Wenger, 2002) towards a more structured approach specifying discrete subjects and based upon achievement of competencies (Spilg et al, 2012; Harden and Stamper, 1999). Such approaches have been linked to political drivers such as performance management and professional regulation (Spilg et al, 2012; O'Reilly and Reed, 2011). Exponents of the spiral curricular model in medicine criticise 'compartmental' curricula for lack of integration and the potential to encourage a silo approach to topics (Harden et al., 1997; Harden and Stamper, 1999). Therefore the move towards 'compartmentalised' competency-based education and labelling, could unintentionally reinforce a separatist view of patient safety, de-contextualising it from practice.

Since completion of this research the 'patient safety' label has become more widespread in nurse education (Howard, 2010; Gantt and Webb-Corbett, 2010; Chenot and Daniel, 2010), encouraged by the World Health Organization (WHO) patient safety curriculum guide for medical schools and subsequent multi-professional version (WHO, 2011; Walton et al., 2010).

The WHO guide acknowledges that patient safety should be integrated, but recognises that most curricula are 'already filled beyond capacity' (Walton et al., 2010, p.545). While short term evaluation of the guide is reported as taking place, long term research into patient safety labelled curricula would be valuable in exploring impacts and consequences such as those predicted by participants in this study. Despite changes in nursing education requirements and increased emphasis on patient safety (NMC, 2010), sampling from degree level programmes means that systems remain similar and findings of the current study continue to resonate with NMC guidance. Furthermore recent reports such as Francis (2013) and Willis (2012) continue to highlight issues picked up in our study suggesting that findings remain current.

A series of issues emerged regarding the organisational context which seeks solutions to problems and conceptualises patient safety as a 'complicated' problem to be split into parts and dealt with via structures, systems, procedures and guidelines (Pearson et al., 2010). This reflects a problem-solving, technical-rational approach (Schön, 1983). However educators, clinical staff and students in this study generally viewed patient safety as complex and embedded, reflecting a 'problem setting' approach which conceptualises patient safety as complex, intricate and relationship dependent – similar to holism (Erickson, 2007). Such differences in conceptualisation parallel different paradigm views in research and professional knowledge (Trifonas, 2009; Steven, 2009; Eraut, 1994) and may compound difficulties in understanding and communication across contexts, potentially creating uncertainty for students. The study also indicated few formal mechanisms for students to learn about organisational strategies and systems: such learning was often ad hoc and reliant upon clinical mentors (Pearson et al., 2010). The flow of information from university to health service organisations was described as limited.

During professional education students move between contexts where different conceptualisations of patient safety seemingly predominate, and across which limited information about student education flows. This situation may create dissonance and unease for students, impinging on their feelings of 'safety for learning'. A further tension seemed to exist regarding error reporting systems, espoused as promoting an open culture and encouraging learning, whilst also acting as a mechanism for dealing with underperformance – embodying what Dodds and Kodate (2011, p.328) term 'dual imperatives of accountability and organizational learning'. Staff may be sceptical of such systems and within the placement setting students may pick up on such feelings.

Students reported discontinuity between the idealised academic world and practice reality. What was deemed safe practice in university was often contrasted with variations in practice. This is a common theme across professional education often called the theory – practice divide (Eraut, 1994). However this discontinuity can also be conceptualised as a contradiction of values (Lipscomb and Snelling, 2010) bound up in differing professional (Pieterse et al., 2012) and knowledge discourses (Steven, 2009). Such contradiction generates unease for students, perhaps compounded by perceptions gained through the 'hidden curriculum' (Bradley et al., 2011) of being taught defensive practice at university. Research in Scotland (Sarac et al., 2011) indicated that staff in organisations where the 'patient safety culture' appeared less positive identified problems including staffing levels, management culture, and prioritisation of safety, as well as safety related behaviours and outcomes. Emphasis on defensiveness and risks of practice may impinge on student confidence, potentially leading to over-tentative practice. Thus students face a series of emotional tensions regarding skill transfer between university and practice settings.

As noted in recent studies (Spilg et al., 2012) a further tension exists within the mentors' role which embodies both educational facilitator and assessor elements. The relationship between student and mentor is crucial to learning (Webb and Shakespeare, 2008), however the current study indicates that students dealt with a series of contradictions and tensions: feelings of distracting staff from patient care; seldom feeling able to challenge or report errors; and an awareness of their junior position within the practice environment and of existing power imbalances.

As reported elsewhere, (Levett-Jones et al., 2009; Levett-Jones and Lathlean, 2008, 2009; Bradbury-Jones et al., 2011a,b) students in the current study clearly felt the need to fit into placement cultures, perhaps seeking what Bradbury-Jones et al (2011b) term a legitimate position. Being accepted into placement cultures and developing trusting respectful relationships with mentors and staff is suggested as important in creating empowering and enabling learning environments (Bradbury-Jones et al., 2011a,b; Smith et al., 2009; Smith, 2012). Smith et al. (2009, p.232) highlights the importance of the

emotional tone of a ward to the learning environment, proposing that 'an emotionally caring climate [makes] the student feel cared for and thus better able to care for others'.

While findings from the current study parallel those of studies previously mentioned in terms of students' desire to 'fit in', an additional finding is the acknowledgement of the contradictory nature of the mentors' role and the influence their power has on students' conformity within placements. Feeling undervalued and fearing potential consequences of questioning practice may militate against the educational value of the placement experience and opportunities to enhance patient safety. Thus students face a series of tensions across contexts potentially leading to 'value dissonance' (Lipscomb and Snelling, 2010) and emotional distress. It is proposed that such dissonance and distress potentially compromise students' 'emotional safety for learning'.

Conclusions

This study offers a comprehensive approach to exploring the process of nurse education from written curricula through academic and practice elements. Conceptualisation of the project around 'knowledge contexts' helps highlight different cultures and knowledge spheres across which nurse education moves, and some of the inherent difficulties encountered.

Academic and organisational views of patient safety differ. The conceptualisation of patient safety within curricula requires further study. More attention needs to be paid to the interface between education and service organisations and to the effects that differing conceptualisations have on student learning. Opportunities for dialogue between organisational contexts and education need to be increased. Patient involvement may help in refocusing such conversations.

Patient safety sits within a complex UK policy context and NHS presently undergoing major reform (DoH, 2010, 2012b). Since 2010, UK policy has primarily focused on avoiding 'never events' (DoH, 2012a) largely relating to surgical and medicine administration errors. In 2012 the NPSA was abolished and its functions moved to a special health authority (DoH, 2012b). The Nursing and Care Quality Forum (NCQF, 2012) noted the importance of commissioning for quality and safety, in education and service delivery. In Scotland, Healthcare Quality Standards (Healthcare Improvement Scotland, 2011) focus on providing assurance about the quality and safety of healthcare through scrutiny and reporting on performance. Some of the areas discussed above offer identifiable areas for further monitoring in this regard.

The research also highlights tensions within organisational and practice contexts. Effective role models in practice are needed and the development of academics and practitioners in relation to patient safety (as well as in understanding their impact on students) is crucial. Further research is needed into the impact of culture on safe practice, and the complex relationships involved. The tensions which students experience across academia and practice may create dissonance and impact negatively on feelings of 'emotional safety for learning', potentially affecting confidence to care effectively for patients. This study has demonstrated the need for nurse educators, managers, educational commissioners and mentors to be aware of the complexities of current educational, organisational and practice contexts in order to create joined up systems that make students feel emotionally safe to work and learn.

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