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Creators: Barchard, F., Sixsmith, J., Neill, S. and Meurier, C.

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Courage, the 6 Cs and 10 commitments: initial findings of a grounded theory research study of nurses' understanding and use of courage

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Abstract

In 2012 the 6 Cs were launched by the chief nursing officer for England, one of which is courage. Leading change, adding value, published in 2016, adds 10 commitments for nursing practice. Much research has been conducted into compassion, competence, caring, communication and commitment, but there is relatively little research of the concept of courage. This article presents the initial findings of a study that explored nurses' understanding of courage. The study used unstructured interview in a grounded theory approach, underpinned with epistemology of social constructionism (Charmaz 2014). 12 qualified nurses were interviewed in depth on their understanding of courage in professional practice. Three initial themes are; being in a situation you don't want to be in, speaking up and taking risks. Understanding Nurses' view of courage and its influence on practice can inform future recruitment and retention policy and practice, enabling preparation and support for nurses using courage in the practice setting.

the 6 Cs, courage, understanding, grounded theory, unstructured interviews

Introduction

This article outlines the initial results of a constructionist grounded theory research study of understanding courage in the context of nursing. Cummings and Bennett (2012) define courage as the attribute that 'enables us to do the right thing for the people we care for, be bold when we have good ideas and to speak up when things are wrong.'

Courage is denoted as an essential nursing attribute in the 6 Cs, one element of the nursing vision (Cummings and Bennett 2012), while Leading Change, Adding Value (Cummings 2016), a new national framework for all nursing, midwifery and care staff, supports these qualities. As Cummings (2016) notes, 'we know that compassionate care delivered with courage, commitment and skill is our highest priority.'

In this she confirms that courage is important to nursing practice. However, despite studies unpacking commitment (Gould and Fontenla 2006), compassion (Straughair 2012 a, b), competence, caring (Rhodes et al 2011), and communication (Kourkouta and Papathanasiou 2014), there is relatively little empirical work on understanding the concept of courage and its role in nursing practice.

Concept of courage

Grounded theory discourages literature reviews before data collection to ensure that understanding derives from participants, rather than from researchers' preconceptions (Glaser 1978). However, Charmaz (2014) acknowledges literature reviews need not be foregone and can indeed be useful, for example in writing research proposals.

Therefore, a preliminary literature review was conducted in 2015 to determine if the subject had been explored. The university library, Nelson, including a wide range of databases such as CINAHL, Cochrane, EthOS, Medline and Ovid, google scholar, and the internet, were searched for research on courage in nursing.

The search terms were 'courage,*' and 'nursing,' in any order in the title or abstract in the last ten years. Articles sought were in English and the field of nursing was not specified. The search revealed no primary research studies in the UK, but located three from outside the UK. Of these two were European (Swedish and Danish), and are Lindh et al (2009), who conducted a hermeneutical enquiry into moral strength, and Thorup et al (2012) whose interpretative study explored courage specific to vulnerability, suffering, and ethics. The third paper originated in New Zealand (Spence 2004), and is a hermeneutic research study exploring courage in practice, which suggests that courage in practice is essential, and raised concluding questions about courage in nursing.

Four more discussion and opinion papers were identified, that met the search criteria. One originated in the UK (Gallagher 2010), and is a discussion paper on the concept of moral distress and courage, and which found this to be an organisational, political and individual responsibility that needs to be emphasised. The other three papers were sourced from the US.

A further 12 papers were identified in the same search with only courage in the title, (ten US, one European, and one UK), are specific to nursing, and are a mix of opinion pieces and discussion articles. The findings indicate that courage is seldom mentioned in nursing literature, which supports Spence (2004) and Murray's (2010) observation.

Lindh et al (2010) state that despite courage identified as a fundamental component of nursing (Spence 2004, Cummings and Bennett 2012), knowledge is lacking regarding nurses' courage in practice. Writers such as Gallagher (2010), Lachman (2010), Lindh et al (2010), Thorup et al (2012), and LaSala and Bjarnason (2010), identify factors that affect the development of courage, including constraints within organisational cultures (Gallagher 2010), nurses' characteristics, such as resilience (Lindh et al 2010), experience, and intuition to provide courageous care (Thorup et al 2012), and creating supportive working environments (LaSala and Bjarnason 2010).

A large number of other papers used words which are similar to courage, for example advocacy, moral strength, or virtue, but these were not included, as the study aimed to

explore courage as defined in the 6Cs (Cummings and Bennett 2012). To truly appreciate what nurses' understand by 'courage' we need to ask them.

Given the paucity of research of courage in nursing (Spence 2004, Lindh et al 2010 and Murray 2010), this study aimed to explore nurses' understanding and use of the concept.

Study

Aims

The aims of the study were to explore how nurses' understanding of courage can inform future practice, thus enabling preparation and support for nurses' using courage in practice settings, and to enhance understanding of adult nurses' use of courage in everyday professional practice.

Three initial themes from analysis of the findings so far are presented and discussed below, and are applied within the context of Leading Change, Adding Value (Cummings 2016). This nursing framework is designed to enable delivery of the triple aims of the Five Year Forward View (NHS England 2014), better outcomes, better experiences for patients and staff, and better use of resources.

Methodology

Constructionist grounded theory was used because of constructionism's social rather than individual emphasis. Nurses do not work in isolation or with individual focus (Nursing and Midwifery Council (NMC) 2015), rather they work within a socially constructed culture, where social processes, historical culture and interactions are evident (Young and Collin 2004, Read 2013). Social constructionism is congruent with grounded theory as an appropriate epistemological model for exploring shared social meaning and understanding (Mills et al 2006). Grounded theory is a structured, but flexible, methodology, and data is collected with simultaneous and sequential analysis (Glaser 2004). Charmaz's (2014) approach includes emphasis on action and co-construction of meaning together with the participant.

Method

Adult nurses were recruited from local acute trusts and the community, through fliers and self-nomination. There were 12 initial participants, all of whom were female. Their practice settings and other demographics are shown in table 1. Most participants had experience of both community and acute settings.

Table 1: Demographics

Participant	Age range	Range of years' experience	Practice setting
P1	53-59	30-35	Acute
P2	32-38	10-15	Community
P3	53-59	30-35	Community
P4	46-52	25-30	Community
P5	53-59	30-35	Acute
P6	46-52	10-15	Acute
P7	25-31	5-10	Acute
P8	46-52	25-30	Acute

P9	46-52	25-30	Community
P10	46-52	25-30	Community
P11	32-38	0-5	Acute
P12	46-52	30-35	Community

Adult nurses were recruited as the researcher is undertaking a professional doctorate and her area of practice is adult nursing. Additionally, the Francis report (Francis 2013) described failings in 'courage' that, while not exclusively related to adult nursing, were mostly in general wards and departments. Unstructured interviews, consistent with constructionist grounded theory (Johan Age 2011), took place in locations chosen by participants and lasted on average one hour. The interviews sought to reveal participants' salient views and meanings about courage (Bowling 2009, Prescott 2009), and the opening question was 'could you tell me what's your understanding of courage in nursing?'

The data were transcribed and coded using line-by-line coding. Data were repeatedly re-examined, receptive to unexpected directions depending on the information itself (Charmaz 2014). The aim was to analyse the data rather than simply describe it (Corbin and Strauss 2008).

While coding, memos, including written explanations, ideas and linkages about the data, helped to strengthen and build categories (Charmaz 1983), enabling movement from description to conceptualisation (Charmaz 2012). NVivo software tool was used which encourages data analysis during collection (Bringer et al 2006, Hutchinson et al 2010, Bazeley 2007). Analysis in grounded theory is an iterative analytical process (Bowling 2009), data collection and analysis are concurrent, and the resultant analysis informs subsequent data collection (Lingard et al 2008, Licqurish Seibold 2011).

Coding the 12 interviews raised 86 codes relating to nurses' understanding and use of courage. The codes were refined into a series of themes, three of which are discussed in this article.

Ethics

Ethical concerns, including anonymity, confidentiality, informed consent, withdrawal, briefing and debriefing, and protection from harm, were all addressed, ethical approval was granted, and recommendations were adhered to. Participants received a comprehensive information sheet detailing their involvement in the study, potential risks of taking part, and what their information was contributing to. They were reassured that consent was entirely voluntary, and that they could withdraw at any point before the analysis stage, after which all data would be anonymised. Data held were anonymised, password protected and securely stored. At the request of the university ethics committee, a protocol was devised in case an issue of concern, for example patient or staff safety, was raised during interviewing.

Findings

The development of a conceptual theory has yet to be completed and, once finalised, will be published in another article. The three initial themes included here are being in a situation you do not want to be in, speaking up, and taking risks.

Being in a situation you do not want to be in

Several participants experienced courage as remaining in a situation they did not want to be in. This involved emotional factors, for example facing their fears, going into the unknown, or feeling out of their comfort zone, and practical knowledge factors such as when to take themselves out of a situation.

P7 talked about dealing with distressing emotional situations in acute settings: '... it's a situation you don't want to be in, that you wouldn't have chosen to be in, so yeah, I think that's courage definitely', while P10 spoke in general terms about her understanding of courage in the community: 'I guess, perhaps being out of your comfort zone from your every day to day, sort of work'.

P9, also a community nurse, spoke of the personal safety aspect of courage and how she faced situations and stayed in them, but also knew when to remove herself: 'Yes, so, so it's courage in the, the true sense of bravery, as in I need to save myself, from, from the situation as it were.'

These participants illustrated various situations they had to stay in, when they would have rather not. Examples ranged from dealing with a challenging family or patient, distressing situations such as unexpected deaths, and walking into situations that were unknown, such as a new patient in the community. Most had not previously considered these as courageous acts until they were asked to reflect on them, and then they agreed with the sentiment expressed by P7: 'Actually lots of things that we do were courageous but we don't really think of it like that.'

This theme suggests that nurses are prepared to face discomfort, stay in situations when they are needed, and will face their fears, however it is not easy and may require nurses to tolerate personal discomfort, as P6 noted: 'You don't necessarily always feel comfortable in what you're doing...it is, again, it's facing those fears.'

Nurses might need support to continually face these situations for the benefit of their patients.

Speaking up and keeping quiet

Despite the NMC (2015) expectation that nurses will challenge and question, and the changes to the traditional hierarchical nature of the NHS, and proposal of a new style of leadership (the King's Fund 2012), participants found that it can be difficult to speak up and have a voice.

P3 and P4, both community nurses with more than 30 years' plus experience, said 'It's having the courage to have a voice', and '... having the courage to say "No" to them'. Both were relating their experiences of challenging authority or hierarchical processes if they believed something was wrong.

P2 had a similar experience in an acute setting when two departments were being combined: 'Nobody had the courage to speak up, everybody accepted what happened; why it happened, nobody had the courage to challenge it and if they did challenge it, nobody had the courage to, to back them up and say we can't do this anymore.'

Keen (2009) suggests nurses need to find their voices, but findings here show that even experienced nurses' can find speaking up difficult and challenging. Implications for practice include considering how nurses are educated and developed to find their voices.

Taking risks

Participants suggested that being courageous could be considered as taking risks, and these risks could include losing their registration, opening themselves up to emotional distress, and being placed in the difficult position of having to 'fight' for something they believed in. Despite the current climate post Francis (2013), aggression and whistleblowing were infrequently mentioned.

P10, a community nurse with 25 years' experience, said 'I think it's, it's perhaps, being very brave, taking risks being out of comfort zone, prepared take risks', in the context of having difficult conversations with patients or their families. P4 related both nursing and personal aspects to risk taking as follows '... but at the end of the day I couldn't leave him so I did, but I put my job on the line then, I put my registration on the line', when talking about treating a patient when she was not sure she should. She also said 'I don't know, is compassion connected to courage? I suppose courage in letting yourself feel', as she recalled a particular patient who she still felt emotionally distressed after 20 years.

These quotes suggest a complex interplay of different facets in relation to risk. Participants discussed aspects including bravery, physical and psychological risk, and fear of losing their registration. Some interpreted risk differently, as letting yourself feel exposed to personal emotional pain when practising compassion. Overall this theme has depth and complexity, and implications for practice include supporting nurses to manage the risks they face.

Discussion

Initial findings of the three themes indicate some of nurses' understanding of courage. Finding the courage to stay in a difficult situation was challenging, and this notion of courage is evident in Gallagher's (2010) and Edmonson's (2010) work. Gallagher (2010) notes that moral distress affects nurses' health and the ability to provide care, which affects job satisfaction, while Edmonson (2010) suggests that distress leads to burn out, desensitisation, and disengagement.

This has implications for the retention of nurses' who may need support, for example through reflection or clinical supervision (Rolfe 2002), to enable them to continue to face these challenges. Revalidation supports reflective practice as the norm, and could enhance retention if nurses use it to unpick some of the difficulties they are confronted with (NMC 2014).

The second theme, speaking out, revealed that nurses need courage to find their voice daily, and this is also identified by Lindh et al (2010) and Lachman (2010). These authors propose that remaining true to their convictions is a struggle for nurses who potentially face losing their job if they speak out, and therefore have to assess the risks of doing so. This is supported by Gallagher (2010), while Francis (2013) noted that staff could be discouraged from speaking out by fear and bullying.

The final theme centred on risk. Lindh et al (2010) also found that courage was related to nurses' willingness to expose themselves to risk. Meanwhile, Gallagher (2010) suggested that organisational, individual or cultural factors can influence this, and proposed that organisations themselves need to embrace moral courage.

The findings of these themes should be considered in the context of recruitment based on value-based interviewing (Health Education England 2016). The implication is that we need

to recruit people who are willing to challenge and take risks, and offer development opportunities in this area throughout professionals' careers, thus enhancing staff retention.

The ten commitments in Leading Change, Adding Value (Cummings 2016) support the desire to deliver care of the highest standard, which requires courage, yet findings from this study, and other evidence, suggest that nurses still find this challenging.

These initial findings suggest that courage is crucial to the realisation of the ten commitments. For example, commitment three 'We will work with individuals, families and communities to equip them to make informed choices and manage their own health', and five 'We will work in partnership with individuals, their families, carers and others important to them', are echoed by P1: 'everything being a test of courage for the best patient outcome'. Meanwhile, P3 and P4 spoke of their difficulty in finding their voices to achieve these commitments.

Commitment 6, 'We will actively respond to what matters most to our staff and colleagues', implies nurses require courage to find their voices, as does commitment nine, 'We will have the right staff in the right places and at the right time'. Finally, and crucially, commitment eight states 'We will have the right education, training and development to enhance our skills, knowledge and understanding'. P9 noted that 'Courage is very closely linked to confidence isn't it, and experience, that if you are confident in your knowledge and you're confident in what you think is right, then you have the courage to shout about it.'

Peate's (2015) article, Without courage the other Cs will crumble, is supported by Walston's (2004) notion that courage enables other virtues. This study suggests that even experienced nurses can find using courage demanding, and this should inform recruitment and retention policies. Not only do we require recruitment of nurses who can challenge and take risks, we also need to ensure there is adequate preparation, training, support and opportunity to enable them to reflect on using courage in practice for retention. As Lachman (2010) notes, courage is far from redundant and is relevant today as nurses encounter numerous situations that call for it.

Limitations

All the voluntary participants were female, adult, nurses, therefore findings and conclusions could be gender and or field specific. The nature of the study means it was time and participant number limited, so it might therefore be difficult to realise true theoretical saturation (Charmaz 2014). Other limitations include that the researchers inevitably brought themselves into the interview (Charmaz 2014), while race, culture, and gender influence what and how things were said, and consequently what was found and written about. Additionally, both researchers and participants belong to 'other identities', for example, nurse, teacher, researcher (Nunkoosing 2005), and these factors influence the conclusions.

To increase the reliability and authenticity of findings, the study procedures have been made clear and are repeatable. Reflexivity is central to the analysis, and to cultivate credibility an audit trail of detailed analysis articulates emergent theoretical concepts (Gasson 2004).

For future studies, it would be interesting to compare results with male nurse participants and nurses from other disciplines and settings to determine if their experiences are similar. This study involved a mix of acute and community nurses, but findings are presented as one. Future studies could explore these settings separately.

Conclusion

The examples in this article, of how nurses confront and remain in difficult situations, take risks and speak out when they fear the consequences for themselves (Francis 2013), are just some of the challenges they face in using courage.

Only the initial coding for the research themes presented in the article is complete, which means that at a conceptual level emergent theory has yet to be explored with further theoretical sampling. However, the implications for practice are becoming clear. Nursing can benefit by considering courage at the point of recruitment, and nurses can benefit from education, support and reflection that begins at recruitment and continues through revalidation, and lifelong learning. This could enable retention of nurses in a profession of which they are immensely proud, but which can be challenging, and comes with a personal cost.

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