

# **Dyslexia in Nursing and Nurse Education: A Case Study**

**by**

**Brendan Gerard Greaney**

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## ABSTRACT

**Aim:** This longitudinal study explores the experiences of six nursing students who have dyslexia in the final six months of their nursing course, revisiting them in their first six months as registered nurses. Additionally, the study explores the experiences of those who support them through this transition from student nurse to registered nurse: their tutors at university, and their mentors and preceptors in practice.

**Background:** Current and past literature exploring the nursing student with dyslexia reveals many have either negative or positive experiences in clinical practice, influenced through the perceptions of others. Additionally, it highlights they experience a variety of difficulties in practice, but many have adopted compensatory strategies to overcome these. There is also evidence of varied levels of understanding of dyslexia, as well as levels of support, from mentors, with evidence of judgmental attitudes towards nursing students with dyslexia. There is limited research surrounding the experiences of registered nurses with dyslexia in practice.

**Design:** A longitudinal interpretative case study design was adopted for this study. Six nursing students with dyslexia in the final six months of their undergraduate nursing course were recruited. The study revisited them within their first six months as registered nurses. The mentors, tutors and preceptors had a direct connection to the student nurses, supporting them either at university or in practice. All participants were interviewed with iterative semi-structured interviews using interpretative phenomenological analysis to analyse the interview data.

**Results:** The students showed degrees of negative self-perceptions, some carried these forward as registered nurses. Some of the mentors, tutors and preceptors lacked knowledge and understanding of dyslexia, with some expressing concerns over the safety of a nurse with dyslexia in practice.

**Conclusion:** The study provides evidence of a dyslexic self-stigma and fear of others' perceptions surrounding dyslexia, but also full acceptance of dyslexia amongst some nurse participants. Dyslexia is perceived differently, with evidence of positive understanding, but also that dyslexia is misunderstood and linked to concerns surrounding patient safety in nursing practice.

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# CONTENTS

CHAPTER 1: Introduction .....	1
1.1 Introduction .....	1
1.2 Chapter Outline .....	2
1.3 Dyslexia: An Outline .....	3
1.4 Nurse Education in the UK .....	4
1.5 Dyslexia and Nursing: The Research to Date .....	5
1.6 Aims of the Study .....	9
1.7 Study's Contribution .....	9
1.8 Structure of the Thesis .....	11
CHAPTER 2: Dyslexia – an Overview .....	13
2.1 Introduction .....	13
2.2 History of Dyslexia .....	14
2.3 Defining Dyslexia .....	16
2.4 Public and Legislative Policy and Dyslexia .....	23
2.5 Neurological Basis of Dyslexia .....	25
2.6 Societal View of Dyslexia .....	27
2.7 The Shared Theoretical Framework of Dyslexia .....	29
2.8 Chapter Summary .....	32
CHAPTER 3: Literature Review – Dyslexia in Nursing .....	33
3.1 Introduction .....	33
3.2 Literature Review Purpose .....	33
3.2.1 Literature Search 1 .....	35
3.2.2 Literature Search 2 .....	40
3.2.3 Literature Search 3 .....	42
3.3 Key findings and Discussion of Core Studies .....	43
3.4 Dyslexia in Nurse Education .....	47
3.4.1 The Development of Nurse Education in the UK .....	47
3.4.2 Dyslexia in Higher Education .....	51
3.5 Dyslexia and Nurses in Clinical Practice .....	56
3.5.1 Nurses with Dyslexia – Difficulties in Practice .....	56
3.5.2 Classification of Dyslexia Versus Non-dyslexia .....	63

3.5.3 The Role of the Nurse Mentor and Nurse Preceptor .....	65
3.5.4 Perceptions of Dyslexia by Mentors .....	67
3.5.5 The Disclosure of Dyslexia .....	70
3.6 The Nursing and Midwifery Council – Fitness to Practise and Safety in Practice .....	75
3.6.1 Safety and the Nurse with Dyslexia .....	75
3.6.2 The Nursing and Midwifery Council and Fitness to Practise .....	84
3.6.3 Reasonable Adjustment and Competence.....	87
3.7 Perception of Self and Dyslexia .....	91
3.7.1 Perception of Self and Identity in Dyslexia.....	92
3.7.2 Self-Esteem and Dyslexia.....	96
3.8 Summary of Chapter Content .....	101
3.9 Development of Research Questions from the Literature Review.....	106
3.10 Chapter Summary .....	117
CHAPTER 4: Methodology and Design.....	119
4.1 Introduction .....	119
4.2 Context of the Study.....	119
4.3 Sample of Participants .....	121
4.3.1 Nursing Students .....	121
4.3.2 Mentors.....	126
4.3.3 Nurse Tutors .....	127
4.3.4 Preceptors .....	129
4.3.5 Registered Nurses .....	131
4.4 Ethical Considerations .....	131
4.5 Case Study .....	136
4.6 Theoretical Framework .....	139
4.7 Methodology.....	146
4.8 Design Frame.....	151
4.8.1 Interpretative Phenomenological Analysis (IPA) and Phenomenology ...	151
4.8.2 Positionality.....	155
4.8.3 Collection of Data – Interviews .....	163
4.8.4 Longitudinal Study .....	177

4.8.5 Triangulation and Case Study.....	179
4.9 Chapter Summary.....	184
CHAPTER 5: Analysis and Findings of Research Data – Nursing Students/Registered Nurses.....	186
5.1 Introduction .....	186
5.2 Stages of the IPA Process .....	186
5.3 Case 1 – Nursing Students .....	189
5.3.1 Step 1 of IPA – Reading and Re-reading.....	189
5.3.2 Step 2 of IPA – Initial Noting .....	190
5.3.3 Step 3 – Developing Emergent Themes .....	201
5.3.4 Step 4 Searching for Connections across Emergent Themes .....	203
5.3.5 Step 5 – Moving to the Next Case .....	207
5.3.6 Step 6 – Looking for Patterns across Cases.....	207
5.4 Case 2 – Registered Nurses .....	207
5.4.1 Step 1 – Reading and Re-reading.....	207
5.4.2 Step 2 – Initial Noting.....	208
5.4.3 Step 3 – Developing Emergent Themes .....	221
5.4.4 Step 4 Searching for Connections across Emergent Themes .....	224
5.4.5 Step 5 – Moving to the next Case.....	235
5.4.6 Step 6 – Looking for Patterns across Cases.....	235
5.4.7 Summary of Chapter.....	237
CHAPTER 6: Analysis and Findings of Research Data – Mentors, Tutors and Preceptors .....	239
6.1 Introduction .....	239
6.2 Case 3 – Mentors.....	240
6.2.1 Step 1 – Reading and Re-reading of Data .....	241
6.2.2 Step 3 – Developing Emergent Themes (Mentors) .....	246
6.2.3 Step 4 – Searching for Connections across Emergent Themes (Mentors) .....	249
6.2.4 Step 5 – Moving to the Next Case .....	253
6.2.5 Step 6 – Looking for Patterns across Cases.....	253
6.3 Case 4 – Tutors.....	254
6.3.1 Step 1 – Reading and Re-reading.....	255

6.3.2 Step 2 – Initial Noting.....	256
6.3.3 Step 3 – Developing Emergent Themes (Tutors).....	262
6.3.4 Step 4: Searching for Connections across Emergent Themes (Tutors) ..	265
6.3.5 Step 6 – Looking for Patterns across Cases.....	269
6.4 Case 5 – Preceptors .....	269
6.4.1 Step 1 – Reading and Re-reading.....	270
6.4.2 Step 2 – Initial Noting.....	271
6.4.3 Step 3 – Developing Emergent Themes (Preceptors).....	278
6.4.4 Step 4 – Searching for Connections across Emergent Themes .....	281
6.4.5 Step 6 – Looking for Patterns across Cases.....	283
6.5 Analysis of NMC Policy Documents .....	287
6.5.1 Method of Findings .....	288
6.5.2 Character and Health Decision-making Guidance (NMC 2015).....	289
6.5.3 Document Summary .....	294
6.5.4 When Studying to be a Nurse or Midwife – Good Health, Fitness to Practice and Guidance (NMC 2016b) .....	295
6.5.5 Document Summary .....	298
6.5.6 Health and Character Guidance for Approved Education Institutions (AEIs) (NMC 2016c) .....	299
6.5.7 Summary of Document .....	300
6.6 Chapter Summary.....	300
CHAPTER 7: Discussion.....	302
7.1 Introduction .....	302
7.2 Case 1 and Case 2 – Nursing Students/Registered Nurses .....	303
7.2.1 Theme 1 – School Experiences .....	303
7.2.2 Disclosure of Dyslexia in Practice – Nursing Students.....	312
7.2.3 Disclosure – Registered Nurses .....	315
7.2.4 Drug Administration – Nursing Students .....	319
7.2.5 Drug Administration – Registered Nurses.....	320
7.2.6 Documentation – Nursing Students .....	322
7.2.7 Documentation – Registered Nurses .....	325
7.2.8 Clinical Handovers – Nursing Students.....	327
7.2.9 Clinical Handovers – Registered Nurses .....	328

7.2.10 Self-perception – Nursing Students .....	330
7.2.11 Self-perception – Registered Nurses .....	333
7.2.12 Changes since becoming a Registered Nurse .....	338
7.3 Case 3 – Mentors.....	348
7.3.1 Understanding of Dyslexia .....	348
7.3.2 Self-perception of Dyslexia .....	350
7.3.3 Personal Experiences of Mentors .....	352
7.3.4 Disclosure .....	354
7.4 Case 4 – Nurse Tutors .....	356
7.4.1 Understanding of Dyslexia .....	356
7.4.2 Perceptions of Dyslexia .....	358
7.4.3 Experiences with a Dyslexic Student .....	359
7.5 Case 5 – Preceptors .....	361
7.5.1 Understanding of Dyslexia .....	362
7.5.2 Perceptions of Dyslexia .....	364
7.5.3 Experiences of Preceptors to a Nurse with Dyslexia.....	366
7.6 Discussion of NMC Documents.....	368
7.7 Chapter Summary.....	371
CHAPTER 8: Further Development of the Theoretical Framework .....	372
8.1 Introduction .....	372
8.2 Development of the Framework .....	373
8.3 Frith Shared Framework .....	374
8.4 International Classification of Functioning, Disability and Health .....	376
8.5 Development of the Adult Dyslexia Framework.....	383
8.6 Adoption and Critique of the Adult Dyslexia Framework (ADF).....	386
8.7 Summary of Chapter .....	391
CHAPTER 9: Conclusion .....	393
9.1 Introduction .....	393
9.2 Limitations of the Study.....	393
9.3 Implications of the Theoretical Framework for Future Practice .....	394
9.4 Research Questions.....	396
9.5 Confidence in Research Findings .....	413

9.6 Recommendations for Future Research .....	415
9.7 Final Thoughts .....	418
REFERENCES .....	420
APPENDIX 1: Nursing Students – Data Analysis Tables .....	468
APPENDIX 2: Registered Nurses – Data Analysis Tables .....	495
APPENDIX 3: Mentors – Data Analysis Tables.....	504
APPENDIX 4: Tutors – Data Analysis Tables.....	530
APPENDIX 5: Preceptors – Data Analysis Tables .....	550
APPENDIX 6: Participant Information Sheet – Nursing Students/Registered Nurses ..	570
APPENDIX 7: Participant Information Sheet – Mentors .....	573
APPENDIX 8: Participant Information Sheet – Tutors .....	576
APPENDIX 9: Participant Information Sheet – Preceptors.....	578
APPENDIX 10: Consent Form for all Participants .....	580
APPENDIX 11: Nursing Student Interview Questions .....	581
APPENDIX 12: Registered Nurses Questions.....	583
APPENDIX 13: Mentor Interview Questions.....	585
APPENDIX 14: Preceptor Interview Questions .....	587
APPENDIX 15: Tutor Interview Questions.....	589
APPENDIX 16: Research Recruitment Flyer.....	590
APPENDIX 17: Nursing Students – Emergent Theme Diagrams.....	592
APPENDIX 18: Registered Nurses – Emergent Theme Diagrams.....	596
APPENDIX 19: HEI 1 Ethics Approval Letter 2013-2014 .....	600
APPENDIX 20: HEI 1 Ethics Approval Letter 2014–2015 .....	601
APPENDIX 21: HEI 2 Ethics Approval E-mail .....	602

## LIST OF TABLES

Table 3.1 – Literature search inclusion and exclusion criteria .....	36
Table 3.2 – List of nursing and dyslexia articles identified in initial literature search 1 .....	37
Table 3.3 – List of additional nursing and dyslexia articles identified in June 2015 literature search 2.....	41
Table 3.4 – Difficulties in clinical tasks experienced by dyslexic nursing students/nurses .....	57
Table 3.5 – Categories of common areas of difficulty from study findings.....	61
Table 3.6 – Difficulties experienced by nurses with dyslexia in practice.....	62
Table 4.1 – Inclusion and exclusion criteria for recruitment of nursing students	123
Table 4.2 – Summary of the nursing students recruited for this study.....	125
Table 4.3 – Mentor participants recruited for this study.....	127
Table 4.4 – Nurse tutor participants recruited for this study .....	129
Table 4.5 – Preceptor participants recruited for this study .....	130
Table 4.6 – Registered nurses’ areas of employment .....	131
Table 5.1 – Initial notes and observations from nursing student transcripts .....	190
Table 5.2 – Interview with Emma – disclosure (nursing student).....	192
Table 5.3 – Case 1 – six nursing students’ initial themes (phase 1).....	201
Table 5.4 – Emergent themes for case 1 – nursing students .....	204
Table 5.5 – Initial notes and observations from registered nurse transcripts.....	207
Table 5.6 – Interview with Emma – changes since becoming a registered nurse .....	209
Table 5.7 – Case 1 – six nursing students’ initial themes (phase 1).....	222
Table 5.8 – Case 2 – six registered nurses’ initial themes (Phase 2).....	222
Table 5.9 – Contrasting emerging themes between case 1 and case 2 .....	225
Table 5.10 – Summary of patterns across themes from participants for cases 1 and 2 .....	230
Table 5.11 – Table of master themes from students/registered nurses.....	235
Table 6.1 – Mentor links to students in the study .....	240
Table 6.2 – Initial notes and observations from mentor transcripts .....	241
Table 6.3 – Interview with mentor 1A (theme H), disclosure of dyslexia .....	242
Table 6.4 – Case 3 – mentors’ initial themes (phase 1) .....	246
Table 6.5 – Connections across emergent themes (mentors).....	250
Table 6.6 – Master themes from case 3, mentors .....	254
Table 6.7 – Tutors and nursing students .....	255
Table 6.8 – Initial notes and observations from tutor transcripts .....	256
Table 6.9 – Interview with tutor 1A, knowledge and understanding of dyslexia (theme M) .....	256
Table 6.10 – Case 4 – tutors’ initial themes (phase 1) .....	263
Table 6.11 – Master themes from case 4, tutors .....	269

Table 6.12 – Registered nurses and preceptors' connections.....	270
Table 6.13 – Initial notes and observations from preceptor transcripts .....	271
Table 6.14 – Interview with preceptor 2B, experiences of being a preceptor to a nurse with dyslexia (theme Q) .....	271
Table 6.15 – Initial themes from case 5, preceptors .....	278

## LIST OF FIGURES

Figure 2.1 – Frith’s Dyslexia Framework .....	31
Figure 4.1 – Diagrammatic representation of the differing factors highlighted in the literature review that form the exploratory elements of my study.....	149
Figure 4.2 – Interview schedule.....	176
Figure 4.3 – Diagrammatic representation of the methods and analysis used within this longitudinal case study design .....	183
Figure 5.1 – Record of interviews – phase 1 .....	187
Figure 5.2 – Record of interviews – phase 2 .....	188
Figure 5.3 – Summary of key influences and statements on disclosure of dyslexia .....	193
Figure 5.4 – Summary of key statements and impact from school experiences relating to dyslexia.....	194
Figure 5.5 – Summary of Key Points and statements regarding drug administration.....	196
Figure 5.6 – Summary of key areas of difficulties/experiences with documentation experienced by nursing students with dyslexia .....	198
Figure 5.7 – Summary of fears surrounding clinical handover amongst nursing students with dyslexia .....	199
Figure 5.8 – Summary of self-perceptions about dyslexia from nursing students with dyslexia .....	200
Figure 5.9 – Emergent themes – self-perception of dyslexia (student nurses) ..	202
Figure 5.10 – Emergent themes – drug administration (student nurses) .....	202
Figure 5.11 – Summary of dyslexic registered nurse comments on changes since becoming a newly registered nurse.....	211
Figure 5.12 – Summary of dyslexic registered nurse comments on disclosing dyslexia as a newly registered nurse.....	212
Figure 5.13 – Summary of dyslexic registered nurse comments on familiarity of nursing tasks .....	213
Figure 5.14 – Summary of dyslexic registered nurse comments on drug administration.....	215
Figure 5.15 – Summary of dyslexic registered nurse comments on clinical handover .....	217
Figure 5.16 – Summary of dyslexic registered nurse comments on documentation.....	219
Figure 5.17 – Summary of dyslexic registered nurse comments on self-perception .....	220
Figure 5.18 – Emergent themes – self-perception of dyslexia (student nurses)	223
Figure 5.19 – Emergent themes – self-perception of dyslexia (registered nurses) .....	223

Figure 5.20 – Emergent themes – changes since becoming a registered nurse (Registered Nurses) .....	232
Figure 5.21 – Emergent themes – familiarity/confidence in nursing tasks (registered nurses) .....	233
Figure 6.1 – Emergent themes H – disclosure of dyslexia, mentor .....	247
Figure 6.2 – Emergent themes I – personal experiences of mentor to dyslexic student .....	247
Figure 6.3 – Emergent themes K – perception of nurses with dyslexia, mentor	248
Figure 6.4 – Emergent themes G – understanding of dyslexia, mentor.....	248
Figure 6.5 – Emergent themes M – understanding of dyslexia, tutor .....	263
Figure 6.6 – Emergent themes N – personal experiences with a dyslexic student, tutor .....	264
Figure 6.7 – Emergent themes O – perceptions of dyslexia, tutor.....	264
Figure 6.8 – Emergent theme P: knowledge and understanding of dyslexia – preceptor .....	279
Figure 6.9 – Emergent theme Q: experiences of supporting a nurse with dyslexia, preceptor .....	280
Figure 6.10 – Emergent theme R: perceptions of dyslexia, preceptor.....	280
Figure 6.11 – Patterns across themes for mentors, preceptors and tutors .....	287
Figure 8.1 – Frith’s Dyslexia Shared Framework.....	375
Figure 8.2 – International classification of functioning, disability and health (WHO 2001) .....	377
Figure 8.3 – The original ICF scheme is expanded with concepts from the model of Van Dijk et al. (1990) and from a proposed subdivision of the personal factors (Heerkens et al. 2012) .....	381
Figure 8.4 – Adult Dyslexia Framework.....	384
Figure 8.5 – ADF Emma – student.....	387
Figure 8.6 – ADF Emma – RN.....	388
Figure 8.7 – Lucy – RN .....	389
Figure 8.8 – Lucy – student.....	390

## LIST OF PHOTOS

Photo 5.1 Emergent themes from case 1 and case 2.....	224
Photo 6.1 Connections across emergent themes – mentors.....	249
Photo 6.2 Connections across statements within themes – case 4 tutors.....	265
Photo 6.3 Connections across statements within themes – case 5 preceptors.....	281

## **ABBREVIATIONS**

ADF – Adult Dyslexia Framework

AEI – Approved Education Institution

HE – Higher Education

HEI – Higher Education Institution

ICF – International Classification of Functioning, Disability and Health

IPA – Interpretative Phenomenological Analysis

NMC – Nursing and Midwifery Council

RCN – Royal College of Nursing

RN – Registered Nurse

SpLD – Specific Learning Difficulty

UK – United Kingdom

# **CHAPTER 1: Introduction**

## **1.1 Introduction**

Dyslexia is a subject much debated over many years. with disagreement amongst academics, educationalists, parents, teachers and lay people over what it is and how it affects those who have it, This argument and debate continues unabated today; the list of definitions and theories as to what it is and what it is not grows in length through countless books, publications, conference papers and articles. This growing body of evidence demonstrates ever-increasing knowledge, awareness and debate about dyslexia, as well as a contested contention amongst many on what dyslexia actually is, as well as what it is not, and how it might impact upon the individual concerned. Therefore, in face of the disagreement surrounding dyslexia, there is a collective agreement that dyslexia remains a matter of great contention.

Dyslexia affects a large number of the United Kingdom (UK) population; current estimates suggest between three and ten per cent (Snowling 2000). More recently, the British Dyslexia Association (BDA) (2014) estimated that approximately 8–10% of the general population are identified as dyslexic. However, it is argued that any consideration within research given to those who have dyslexia and how it impacts them professionally and personally in their working lives, is often overlooked. For example, Snowling (2000), who has written extensively on dyslexia, considers definitions, hypotheses, presentation and a biological basis, as well as help for dyslexics.

Other texts that explore dyslexia take quite a broad medical focus exploring impairments, diagnosis and assessments, alongside neurological and genetic links (Jenner, Rosa & Galaburda 1999; Miles 2001; Finch, Nicholson & Fawcett 2002). Fitzgibbon and O'Connor (2002) argued that such developments are unlikely to influence strategies for helping adult dyslexics to improve their performance in the workplace. Burden (2005: 9) claims that 'there appears to be comparatively little research into how dyslexic children and adults make sense of their dyslexia and how it affects their perceptions of themselves as learners or as citizens of the world'. From this perspective, it is surmised that there is limited research of the dyslexic voice. We hear these voices second hand from researchers, but often not at any great length or in detail. This is important because arguably, how can we have a true understanding of dyslexia and its true impact until we hear from those who are dyslexic. We can consider types, characteristics and presentations of dyslexia, but this tells us very little about the personal and professional impact upon the individual with dyslexia.

## **1.2 Chapter Outline**

This chapter introduces the reader to the study and briefly presents the subsequent chapters of this thesis. The chapter opens with an outline of dyslexia, specifically the contention surrounding dyslexia, and identifies a common agreed definition of the term. This is followed by a brief summary of the organisation of nurse education in the UK. An overview of the literature that informed the study is then provided specifically the literature that has explored dyslexia and nursing. The significance and contribution of this study is then presented before the chapter concludes with the overall aims of the study and a brief outline of the thesis.

### 1.3 Dyslexia: An Outline

As highlighted in the introduction, dyslexia is a subject that has received much debate and argument; however, what is the source of this conflict? Snowling (2000) suggests that the controversy surrounding dyslexia relates to the use of the term itself to describe a multitude of reading problems. Elliott and Grigorenko (2014) argued how we should best understand and address literacy problems across a variety of policy contexts including education and occupation. Disputes continue as to whether there is or is not such a thing as dyslexia (Pavey et al. 2010). However, to place dyslexia within the context of such arguments, it is important to first define it and essentially 'pin it down'.

There are many definitions of dyslexia, which adds to the difficulty in defining it, as well as adding to the contention surrounding it, but in examining a variety of these, a consensus of agreement on the literacy difficulty that is apparent in those who are identified as dyslexic can be found. Elliott and Grigorenko (2014) stated that most parties agree that the definition should concern particular difficulties encountered by those who struggle to read text. The International Dyslexia Association (2002) defines dyslexia as '*...characterized by difficulties with accurate and/or fluent word recognition and by poor spelling and decoding abilities*'. Sir Jim Rose's 2009 Report, *Identifying and teaching young people with dyslexia and literacy difficulties*, describes dyslexia as a learning difficulty that primarily affects the skills involved in accurate and fluent word reading and spelling (Rose 2009: 29). *The British Dyslexia Association (2007) in its definition describes dyslexia as a specific learning difficulty that mainly affects the development of literacy and language related skills. These, and many other definitions refer to difficulties with literacy and language; therefore, it can be determined that*

dyslexia is clearly characterised by aspects of difficulties in literacy. A further in-depth discussion of how we can define dyslexia is presented in Chapter 2.

## **1.4 Nurse Education in the UK**

The organisation of the education and training of nurses has undergone a number of significant developments over the past three decades. Currently nursing students undertake a three-year programme based at university and split their time equally between university-based theoretical modules and hospital-based clinical placements, which must consist of at least 4,600 hours (NMC 2010a). On commencing a programme, nursing students can choose from four branches of nursing practice: adult, mental health, learning disability or children; however, this is dependent upon individual institutions. Overall, the programme requires 50 per cent theory (2,300 hours) and 50 per cent practice (2,300 hours) (NMC 2010a: 9). A nurse mentor (a registered nurse who has completed a course of study in specific preparation for assessing students) is normally responsible for ongoing supervision and assessment of the nursing student in practice settings and the assessment of clinical competence.

The assessment of clinical competence is an essential requirement for entry to the Nursing and Midwifery Council's (NMC) professional nursing register. The NMC (2010b: 11) define competence as 'the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions'. These competencies are organised into a competency framework, which sets out the standards for competence and the related competencies that every nursing student must achieve to ensure registration on the professional nursing register. The competency framework, divided into four domains, comprising

- Professional values,

- Communication and interpersonal skills’,
- ‘Nursing practice and decision-making’
- Leadership, management and team working’.

To achieve these competencies, nursing students must apply both knowledge and skills based on current and best available evidence that is indicative of safe nursing practice. Safety is one of the key cornerstones of the regulatory responsibilities of the NMC, who state as part of their mission statement, ‘...our role is to protect patients and the public through efficient and effective regulation’ (NMC 2017b). A more detailed overview of the history and development of nurse education in the UK will be presented in Chapter 3.

### **1.5 Dyslexia and Nursing: The Research to Date**

This study stems from my own personal interest in dyslexia within the arena of nursing. This has developed over a number of years through my professional experience as a nurse academic and my subsequent contact with nursing students who have dyslexia within higher education (HE). Additional to these influences are the findings of my MA thesis, which explored dyslexia amongst a sample of six nursing students (Greaney 2007). This study’s findings revealed the multiple and varied difficulties dyslexic nursing students experience in clinical placement, along with evidence of a lack of understanding about dyslexia from some nurse mentors. However, this study did not explore in any depth the nurse mentor’s perceptions of dyslexia and a number of questions remained unanswered; specifically, what happens once a nursing student with dyslexia becomes a registered nurse and is the question of safety truly a justifiable issue of concern surrounding a nurse with dyslexia?

No statistics are available that establish the existence or percentage of dyslexia amongst healthcare professionals (Morris & Turnbull 2007a). However, Jelly (2014) estimated that between three to ten per cent of the nursing population admit to having dyslexia, but this only offers an approximate figure rather than statistical confirmation. The research surrounding dyslexia and nursing to date has explored, for the most part, dyslexia amongst nursing students (Shellenbarger 1993; Wright 2000; Price & Gale 2006; Sanderson-Mann & McCandless 2005; Morris & Turnbull 2006; White 2007; Child & Langford 2011; Ridley 2011; Sanderson-Mann et al. 2012; Evans 2014a). This research collectively identified a range of difficulties that nursing students in clinical practice face including difficulty in spelling, retaining information and writing nursing reports, for example. Additionally, a number of these studies identified evidence of negative attitudes from nursing colleagues and mentors towards nursing students with dyslexia (Price & Gale 2006; Morris & Turnbull 2006; White 2007; Ridley 2011; Evans 2014a). Some of these studies also highlighted an unwillingness to disclose dyslexia amongst nursing students for fear of a negative reaction and being seen in a less positive light (Morris & Turnbull 2007a; White 2007; Sanderson-Mann & McCandless 2005; Ridley 2011; Evans 2014a).

However, in contrast, these same studies also noted that some dyslexic nursing students were willing to disclose their dyslexia to mentors in practice for reasons such as access to support and a sense of responsibility for patient safety, as well as evidence of positive reactions to their dyslexia by some mentors. These studies raise a number of points. Firstly, variability in the level of difficulty dyslexic nursing students face in clinical practice, particularly the experience of negative reactions to their dyslexia by those who they work with. This suggests evidence of a degree of stigma

surrounding dyslexia within nursing. It is significant that the studies previously highlighted have all explored dyslexia amongst nursing students. Based on my review of the literature, there are only two studies, both from the UK, that have specifically explored dyslexia amongst registered nurses with dyslexia (Illingworth 2005; Morris & Turnbull 2007a) illustrating a gap in this area of research. These two studies found dyslexic nursing students faced similar difficulties in clinical practice, but also noted some negative reactions from others in practice towards their dyslexia.

The research surrounding dyslexia in nursing has only developed in the last 20 years. James (2006) claimed nursing is one of the subjects with the highest proportion of dyslexic students, along with design studies and computing science. Therefore, it can be surmised that awareness of dyslexia in nursing is relatively recent within nursing, but raises the question as to what initiated this awareness and interest in dyslexia and nursing. It is argued that the advent of UK disability legislation such as the Disability Discrimination Act (HMSO 1995) and the later Equality Act (2010) could be one possible reason for this as NHS trusts and higher education institutions (HEIs) were obliged to meet disability requirements under this new legislation.

A relatively new area of research such as this brings scope for further and more in-depth research, particularly surrounding registered nurses with dyslexia and their subsequent experiences during the post-registration phase of their career. There exists limited research surrounding the experiences of nursing students with dyslexia within the university environment. Based on my review of the literature, there appears to be only one piece of research that has specifically explored the perceptions of nurse lecturers surrounding dyslexia (Evans 2014b). Nurse lecturers play a key role through both education and support in preparing nursing students for a future nursing career,

utilising both training and education within the HE environment to achieve this goal. Evans (2014b) interviewed 19 nurse lecturer participants, of whom a small number questioned the safety of a nursing student with dyslexia specifically around drug administration. Despite Evans' study (2014b) being the only one specifically exploring the perceptions of dyslexia amongst nurse lecturers, it does reveal some evidence of negative attitudes towards dyslexia and nursing amongst this sample. This contrasts also with the negative attitudes of some mentors towards nursing students previously highlighted (Price & Gale 2006; Morris & Turnbull 2006; White 2007; Ridley 2011; Evans 2013). Collectively this evidence of negative perceptions of dyslexia within nursing warrants further investigation.

The studies around dyslexia and nursing highlighted in this chapter are to be collectively explored and analysed in greater depth in the literature review chapter (Chapter 3). At a glance, these studies present a 'snapshot' view of nursing and dyslexia, offering perspectives from the dyslexic nursing student, from the dyslexic nurse, and perceptions and experiences of dyslexia from nurse mentors. What was absent from these studies, at any great length, were the evocative voices of those nursing students and nurses who have dyslexia, as well as those who support them in clinical practice and at university. The significance of this study is its aim to explore the experiences of nursing students with dyslexia through to their experiences as registered nurses. In addition, its aim is to explore the experiences and perceptions of those who support them through this journey, namely nurse tutors, mentors and preceptors. Currently, no study has followed a longitudinal route in the exploration of the experiences of dyslexic nursing students and registered nurses or collectively researched tutors, mentors and preceptors as part of that same study.

## **1.6 Aims of the Study**

This study addresses the direct life experiences of nursing students with dyslexia who subsequently go on to become registered nurses. From this perspective of exploring their transitional development from student to registered nurse, this study aims to take a longitudinal view. The aims of this study are as follows:

1. Investigate influences that might shape the professional and educational experiences of dyslexic nursing students both at university and within clinical practice
2. Determine how such influences and experiences potentially change as these nursing students become registered nurses
3. Investigate the perceptions, experiences and understandings of those who directly support these dyslexic nursing students through this transitional journey to registered nurse
4. Examine the professional position of the Nursing and Midwifery Council (NMC) surrounding disability and specifically dyslexia

A more detailed discussion of these aims and in-depth details of the methodology and design of this study will follow in Chapters 3 and 4.

## **1.7 Study's Contribution**

This study aims to present a depiction of dyslexia in nursing and nurse education through the voices of the participants. It aims to do this through a longitudinal view detailing not only the perspectives and personal experiences of nursing students with dyslexia, who later become registered nurses but also the perceptions and understandings of those who support these nurses at various stages throughout this

journey, namely nurse tutors, mentors and preceptors. This study does not attempt to generalise its findings to the wider population of dyslexic nurses across the UK, but instead aims to provide insight into dyslexia in nursing and nurse education, specifically through the perspectives of two HEIs and six NHS trusts. However, it is anticipated that through dissemination, this study might bring about change in the context of nurses with dyslexia not only through broadening understanding of dyslexia in nursing but also in the long term, bringing about a greater acceptance of dyslexia within the profession. In addition, that the influences of this study will also improve the understanding of dyslexia within similar HE professional healthcare courses such as midwifery, physiotherapy, radiography and paramedic science, adding to the evidence base within this developing area of research.

As has been previously highlighted in this chapter, based on my review of the literature, there are only two known studies surrounding registered nurses with dyslexia (Illingworth 2005; Morris & Turnbull 2007a), and only one known study that explores nurse lecturers' attitudes to nursing students with dyslexia (Evans 2014b). There is no evidence of any study that has explored specifically preceptors' attitudes to nurses with dyslexia. Therefore, my study aims to present a unique insight into a dyslexic nursing student's journey from nursing student to registered nurse including those who guide and support them through this academic and clinical journey.

This study will adopt an interpretative phenomenological case study approach, detailed in greater depth in Chapter 4 – Methodology and Design.

## **1.8 Structure of the Thesis**

The thesis comprises nine chapters. This introductory chapter has outlined the main topic and some background to the study, the research aims and has presented an overview of the study. Chapter 2 gives an overview of dyslexia. It specifically explores its historical context and presents arguments concerning how dyslexia might be defined, how it is viewed by society and its neurological basis. It concludes with a discussion of Frith's (1995) theoretical model of dyslexia in the context of this study. Chapter 3 presents a systematic literature review of nursing and dyslexia, exploring multiple areas of dyslexia and nursing, specifically difficulties in practice; safety and the nurse with dyslexia; NMC and fitness to practise; disclosure of dyslexia; perception of self and identity in dyslexia; self-esteem in dyslexia; dyslexia in HE; and perceptions of dyslexia by mentors and preceptors. Chapter 3 concludes with a further discussion of the development of the study's research questions.

Chapter 4 presents the methodology and design of the study outlining my ontological and epistemological position, as well as the overall methodology and design frame. Chapters 5 and 6 comprise the analysis of the data. Chapter 5 presents an analysis of the data of the nursing students who later become registered nurses. Chapter 6 follows on from Chapter 5 with an analysis of the data of the mentors, tutors and preceptors and NMC documents. Chapter 7 presents a discussion of the findings. Chapter 8 offers a new dyslexia framework with an outline of the design of this framework influenced by the Frith framework and International Classification of Functioning, Disability and Health (ICF). Chapter 9 concludes with the significance of the findings and provides recommendations for future research in this area.



## **CHAPTER 2: Dyslexia – an Overview**

### **2.1 Introduction**

As highlighted in the introduction, dyslexia remains a subject of both contention and argument. Stampoltzis and Polychronopolou (2009) claimed that dyslexia is controversial, with conflicting debates and positions about its origins, causes, manifestations and treatments. There has been a great deal written about dyslexia from a number of academic disciplines including neurology, psychology, education and sociology. Each of these disciplines has something to contribute in terms of what it is; what might cause it; how it presents in an individual; its social, psychological and professional impact; its management and perception within employment settings; but most importantly, how society perceives it. Today, the debate over dyslexia rages on amongst academics and education professionals who continue to argue over its many concepts and characteristics.

This chapter provides a number of initial insights into dyslexia; firstly, the historical perspective, and secondly how dyslexia might be defined in relation to current evidence given the wide variations in the presentation of dyslexia. Thirdly, current legislative public policy surrounding dyslexia is introduced, with specific reference to reasonable adjustments and competence standards in nursing practice. Fourthly, the neurological basis of dyslexia is examined and how dyslexia is perceived within modern society. The chapter concludes with a discussion of Frith's shared theoretical framework of dyslexia, which attempts to encompass the many elements and influences that surround dyslexia, as well as place it within the context of my own study.

## **2.2 History of Dyslexia**

Lawrence (2009) claimed that societal interest in people with reading difficulties probably first began in 1878 with German neurologist Adolf Kussmaul who had a special interest in adults with reading problems. Kussmaul identified a number of his patients who could not read properly or got words in the wrong order. As a resultant impetus of these findings, Kussmaul introduced the term 'word blindness' to describe such difficulties, though it is argued that the first account of 'word blindness' was presented in 1676 by the physician John Schmidt (Elliott & Grigorenko 2014). However, it was not until the latter part of the nineteenth century that this phrase began to be frequently adopted in medical journals to describe adults and children who had difficulty learning to read, and significantly is still often used today to describe dyslexia. The phrase at that time also reinforced the belief that these patients were neurologically impaired.

The actual word 'dyslexia' was first adopted in 1887 by a German ophthalmologist Rudolf Berlin in place of word blindness to describe a patient who had lost the ability to read due to a stroke. The word 'dyslexia' is of Greek origin with 'dys' meaning difficulty or disordered and 'lexicos' meaning words, collectively meaning difficulty with words. However, the word dyslexia did not come into common usage in the literature until the twentieth century and 'word blindness' was more commonly adopted to describe adults and children with reading problems. In 1891, a report published in the *Lancet* by Dr Dejerne described a patient who had suffered a brain injury following a blow to the head with a crowbar. Because of this injury, this patient had lost several language functions including the ability to read. As a result, a medical hypothesis then emerged that those who had difficulty reading had probably suffered a brain injury.

Following the publication of Dejerne's report, a number of further accounts began to emerge in other medical journals reporting patients who had also suffered brain injuries and subsequently lost the ability to read. A resultant view then developed that persistent reading and language difficulties must always owe their origin to particular brain dysfunctions. This view then began to be generally accepted. The work of Dejerne appeared to reinforce the earlier work of Kussmaul that reading difficulties were associated with underlying neurological impairments. A key fact here is that these conclusions were largely based on a medical hypothesis rather than any proven research. At that time, it appeared to be generally accepted that difficulties in learning should rightly be the province of the medical profession. This seemed to be consistent with the medical model of learning, which remained dominant in the latter part of the nineteenth century. In 1896, a case report in the *British Medical Journal* by Pringle-Morgan (1896) described a 14-year-old boy who, in spite of normal intelligence, had been unable to learn to read. Pringle-Morgan, a general practitioner and Hinshelwood, an ophthalmologist also writing in 1917 of the same case (Hinshelwood 1917), speculated that such difficulties with reading and word blindness were most likely due to a form of 'congenital word blindness'.

Further developments and understanding of dyslexia emerged during the 1930s. American neurologist, Samuel Orton disagreed with the term 'congenital word blindness' positing that the term 'congenital word blindness is misleading, since there is no true blindness in the ordinary sense of the term, nor indeed is there even blindness for words' (Orton 1937: 71). He noted the distorted order of words described by the children with this difficulty in attempting to read. As a result of these observations, he proposed a new term, 'strephosymbolia' meaning twisting of symbols.

Orton was also one of the pioneers in identifying a familial link to dyslexia describing how dyslexia could run in families.

## **2.3 Defining Dyslexia**

As highlighted in Chapter 1, defining dyslexia has become a complex and contentious issue. The debate around dyslexia continues to evolve, and with it are presented new theories as well as solutions, treatments and suggested causes. Historically, since the beginning of the twentieth century, a number of notable researchers have presented descriptions and presentations of dyslexia: 'word blindness' (Hinshelwood 1917); 'strephosymbolia' or twisted symbols (Orton 1937); phonological awareness deficits (Snowling, 2000); double deficit disorder (Wolf & O'Brien, 2001); and automaticity deficits (Fawcett et al., 2001). However, from the opposite end of the debate are some who have dismissed the existence of dyslexia or the actual use of the term 'dyslexia'. Elliott and Gibbs (2008) view dyslexia as a socially defined construct and suggest there appears to be no clear-cut scientific basis for the diagnosis of dyslexia versus poor reader versus normal reader. Elliott and Grigorenko (2014) also argued for the substantial overlap of terms such as specific reading retardation, reading difficulties, specific reading difficulties, reading disability, learning disability and specific learning disabilities. Pollock, Waller and Pollitt (2004) suggested that the term 'specific learning difficulty' not only includes dyslexia, but also attention deficit disorder, dyspraxia and speech and language processing difficulties. Rice and Brooks (2004) conducted a systematic review of the evidence on the nature, incidence, diagnosis and treatment of dyslexia in adults and conclude that the condition was poorly defined and methods for judging the outcomes of 'treatments' were unreliable.

It is argued by Snowling (2000) that one of the key possible reasons for this continued contention and poor definition is the actual use of the term 'dyslexia' to describe a multitude of reading difficulties. There are myriad definitions and descriptions of dyslexia evident within countless books and journal articles; however, as stated by Pavey et al. (2010: 6) '...there is no definition currently in existence that completely satisfies all interested parties'. Similarly, the New Zealand Ministry of Education (2008: 1) stated 'defining dyslexia is a complex and contested process and there are no agreed definitions internationally'. This lack of consensus about a clear definition may potentially be considered as one reason behind the ongoing debate surrounding dyslexia. Brown Waesche et al. (2011: 296) reiterated this lack of consensus: 'Without an agreed-on definition that can be implemented reliably and validly, understanding the nature, causes and best treatments for reading disability is unlikely.'

A list of 11 well-accepted definitions from Pumfrey and Reason (1998) increased to over 40 in a research review by Rice and Brooks (2004). Rice and Brooks went on to describe this lack of clarity over a definition as 'a degree of inconsistency verging on anarchy' (2004: 16). Mortimore (2008) argued that the different disciplines involved in dyslexia such as psychology, neurology and education, for example, each tend to base their work on a particular definition, resulting in many differing definitions. As previously outlined in Chapter 1, a number of definitions of dyslexia have a commonality in respect of referring to difficulties in literacy. It is important to establish a definition of dyslexia, as Rose (2009) speaks of co-occurring difficulties such as aspects of language, motor co-ordination, mental calculation, concentration and personal organisation, making the point these are not in themselves markers of dyslexia. Whilst these difficulties can occur as part of a dyslexic pattern (Rose 2009), there is a need to ensure that they do

not blur the boundaries of what dyslexia is; some of the difficulties above may be caused by issues other than dyslexia.

Early research characterised dyslexia as a difficulty with aspects of literacy, specifically reading. The World Federation of Neurology (1968: 21) stated 'Dyslexia is a disorder manifested by difficulty in learning to read'. More recently, a definition from the BDA (2007) refers to dyslexia as a specific learning difficulty that mainly affects the development of literacy and language related skills. A definition of dyslexia by Turner and Greaney (2010: 231) refers to it as 'persistent literacy learning difficulties, especially difficulties in word recognition, spelling, and phonological recoding'. All these definitions reveal a particular commonality, specifically difficulty in literacy and thus identify dyslexia as having aspects of specific literacy difficulties such as reading, spelling and word recognition. Similarly, the BDA (2007) defined dyslexia in the following way, highlighting the affect upon literacy and language related skills:

Dyslexia is a specific learning difficulty that mainly affects the development of literacy and language related skills. It is likely to be present at birth and to be life-long in its effects. It is characterised by difficulties with phonological processing, rapid naming, working memory, processing speed, and the automatic development of skills that may not match up to an individual's other cognitive abilities.

However in 2009, Sir Jim Rose released an independent report to the Secretary of State for Children, Schools and Families, titled *Identifying and teaching children and young people with dyslexia and literacy difficulties*. This report included a new definition of dyslexia as follows:

Dyslexia is a learning difficulty that primarily affects the skills involved in accurate and fluent word reading and spelling. Characteristic features of dyslexia are difficulties in phonological awareness, verbal memory and verbal processing speed. Dyslexia occurs across the range of intellectual abilities. It is best thought

of as a continuum, not a distinct category, and there are no clear cut-off points.’ (Rose Report: 2009: 9)

This definition again refers to literacy difficulties, but names specific literacy difficulties including accurate and fluent word reading and spelling. Additionally, it highlighted specific characteristic features of dyslexia such as verbal memory and verbal processing speed. This definition relates directly to literacy and information processing difficulties, not only in its use of simpler language, in contrast to the BDA (2007) definition, but also in the context of my own study where nursing students and nurses with dyslexia might experience these specific literacy difficulties in practice. It further describes dyslexia as a continuum, not a distinct category with no clear cut off points, which adds to the view of dyslexia as a variable presentation. Therefore, in determining an operational definition of dyslexia, taking into account the range of definitions previously highlighted, the Rose (2009) definition clearly describes the common range of difficulties encountered by those who have dyslexia. Further reference will be made to this particular definition in subsequent chapters.

Returning to Rose’s (2009) work on co-occurring difficulties, although they are not definitive markers of dyslexia, such difficulties can still occur as part of a dyslexic pattern. This demonstrates that dyslexia sits along a continuum. The Rose Report (2009: 33), *Identifying and Teaching Children and Young People with Dyslexia and Literacy Difficulties*, noted the differences between dyslexics versus non-dyslexics and poor readers stating, ‘Dyslexia is best thought of as a continuum, not a distinct category and there are no clear cut off points.’ Riddick (2000) also claimed there exists a continuum between good, average and poor readers. Snowling (2008) suggested we should conceive of dyslexia as a dimension rather than a category. All of these

statements from the Rose Report, Riddick and Snowling present an increasing blurring of the boundaries over those who have dyslexia, those who do not and those who might be identified as just poor readers. This blurring of the boundaries described provides some explanation for the continued contention surrounding dyslexia.

However, secondary to this, those who are dyslexic present very differently. In 1993, the Moray House Centre for Specific Learning Difficulties consulted a wide range of professionals and concluded that dyslexia can be identified in terms of patterns of information processing difficulties ranging from the very mild to very severe. Mortimore (2008) also reiterated that people with dyslexia show widely different degrees of difficulty. The DFES (2004) stated that people with dyslexia have their own individual profiles of strengths and weaknesses and no two people with dyslexia will be alike. Pavey et al. (2010) pointed out that conceptualisations of dyslexia are so wide and varied that they seem not to be describing one particular phenomenon. Pavey et al. (2010) argue that consequently for some, dyslexia might be understood as an umbrella term. Furthermore, it is reasonable to consider the impact of dyslexia upon an individual, which adds to the differing degrees of dyslexic presentation.

Burden (2005) argued that the human side of dyslexia has been neglected and rather there is a greater focus upon causation and remediation. Alexander-Passe (2015) in a study that explored differences in the dyslexia experience amongst dyslexic adults, noted the differences in life experiences dependent upon school experiences and their differing feelings around labelling, with some considering it a positive thing, others in contrast as negative. This demonstrates the significance of the human element as well as the human impact surrounding dyslexia.

It can be argued, that by our very nature, humans are very different from one another. In this context, how would such differences relate to an individual with dyslexia? Gerber (1994) suggested that placing dyslexia within a lifespan development perspective provides a foundation for an understanding of the adjustment challenges faced by adults with dyslexia. It is important to consider the development of adults in the context of dyslexia. Patton and Polloway (1996) described four main variables that influence our development into adulthood: biological and intellectual, personal and social, past experience and feeling of control over life events. McLoughlin et al. (2002) identified past experience and a feeling of control over life events as particularly important when considering a person with dyslexia, arguing that previous failures and successes have a significant impact upon them.

School experiences and the level of support, specifically the attitudes of teachers towards those who are dyslexic, demonstrate a mixture of both positive and negative experiences in a study by Gibson and Kendall (2010). A number of studies have also emphasised a need for teachers to identify and address not only the academic needs, but also the personal, social and emotional needs of a young person with dyslexia (Riddick 1995, Humphrey 2003;). Certainly, significant life events, particularly those that are negative or we associate with failure, can have an impact upon us. With reference to this point, some studies have added to a growing body of evidence that indicates those with literacy difficulties related to dyslexia are likely to have substantially increased levels of anxiety (Hales 1994; Willcutt & Pennington 2000; Carroll et al. 2005; Carroll & Iles 2006). However, other studies have challenged this view and claimed the influence of negative academic experiences or social experiences can mediate the association between dyslexia and anxiety (Riddick et al.

1999). Other studies have cited environmental influences such as nutrition and lower socio-economic status as implicated in dyslexia and anxiety disorders (Gennetian & Miller 2002; Phillips & Lonigan 2005). This further adds to evidence of the wide variability of external influences upon those who have dyslexia.

Despite ongoing contention surrounding the defining of dyslexia, a number of commonalities can be identified, specifically difficulties with literacy. The Rose Report (2009), as highlighted in his definition, identified the affect upon skills involved in accurate and fluent word reading and spelling. The BDA also identifies the affect upon the development of literacy and language related skills.

Secondary to the debate over a definitive definition of dyslexia, a body of evidence demonstrates the variable presentation of dyslexia amongst those who are dyslexic. The description by Snowling (2008) suggesting dyslexia should be described as a dimension rather than a category and the Rose Report (2009) recommending that dyslexia should be thought of as a continuum rather than a distinct category with no clear cut off points adds to the breadth of dyslexia presentation from one person to another. Additional to this is the diversity of the nature of humans and the variable influences that can impact upon those with dyslexia, such as significant life events like past school experiences and the level of support they receive. The evidence has demonstrated that the impact of dyslexia upon a person can be significant. A number of studies suggest those with dyslexia are likely to have substantially increased levels of anxiety (Hales 1994; Willcutt & Pennington 2000; Carroll et al. 2005; Carroll & Iles 2006), but this has been challenged by others (Riddick et al. 1999). This adds to the contention about dyslexia as well as the many contextual factors that can influence its

overall presentation. It can be concluded that dyslexia is not a singular entity; rather, it is a continuum of varied presentations from one person to another. Further reference to these discussions is made in subsequent chapters.

## **2.4 Public and Legislative Policy and Dyslexia**

Dyslexia is categorised as a disability under the Equality Act (2010). Therefore, those who have dyslexia are entitled to a number of legislative rights under this act, specifically reasonable adjustments. Reasonable adjustments are defined as changes to the work environment that allow people with a disability to work safely and productively (Equality and Human Rights Commission 2010). The Equality Act (2010) makes a number of requirements in relation to reasonable adjustments. One of these requirements states that, 'where a provision, criterion or practice...puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage' (Equality Act 2010: 23). 'A reasonable adjustment removes the disadvantage a disabled person is experiencing as a result of their disability

In relation to dyslexia, the disadvantages a person might experience relate to literacy difficulties, specifically reading or writing or both as previously highlighted in the definition outlined in section 2.4 of this chapter. However, any adjustments for difficulties in literacy due to dyslexia would be varied and based upon the individual needs of the person. As previously highlighted in section 2.3, dyslexia can be thought of as a continuum rather than a distinct category (Rose 2009). A report by Aitken and Dale (2007) reviewed the literature into dyslexia and nursing practice and stated that reasonable adjustments are the responsibility of the employer, but raised the issue of

practicality in terms of cost, disruption and resources. This was outlined in the Equality Act (2010), with reference to 'reasonableness', stating that cost, practicality, effectiveness and resources should be the test as to what is considered reasonable in making any adjustments.

The adjustments required for nursing students with dyslexia must apply in both the university setting as well as the clinical setting. In a university setting, adjustments such as extra time for examinations are easily accessible with the support and guidance of university disability services. In contrast, in a clinical setting the availability of a quiet room is less easily accessible (Pischke-Winn et al. 2003). Additionally, nursing students are required to achieve clinical competencies whilst on clinical placement. This additional requirement is referred to as a 'competence standard' by the Equality Act (2010). A competence standard is defined as, 'An academic, medical or other standard applied for the purposes of determining whether or not a person has a particular level of competence or ability.' In relation to undergraduate nursing courses, HEIs are not required to make reasonable adjustments themselves; rather, they are required to make adjustments to the ways the competence standards are assessed, so that disabled students are not disadvantaged in demonstrating their competence standard by the assessment method (Equality Challenge Unit 2015: 6). These adjustments are not applied to the competencies themselves, but to the support of the student in the method of assessment and attainment to ensure that professional standards are met. Further reference is made to competence standards, reasonable adjustments and disability policy in Chapter 3.

## **2.5 Neurological Basis of Dyslexia**

As early as the nineteenth century, the connection between a severe reading disability and brain function was hypothesised by a number of early pioneers in dyslexia research, specifically the presence of unknown brain lesions (Berlin 1887, Hinshelwood 1895). Morgan (1896) further suggested the involvement of the angular gyrus, a part of the brain that is associated with language, number processing, spatial cognition and memory. Hinshelwood (1902) substantiated this hypothesis from the findings of an autopsy on a patient who had been experiencing reading difficulty. Samuel Orton (Orton 1937) further argued that other portions of the brain could be involved, specifically areas within the left hemisphere. However, despite these innovative ideas from these early pioneers in linking reading difficulties to brain function, they remained only theories. It was not until later into the twentieth century that evidence began to emerge resulting from an increased amount of autopsies performed on those who had experienced reading disabilities in life.

Drake (1968) noted the autopsy case of a boy with a reading disability who had malformations in the left inferior parietal lobe including ectopias, which are small areas of abnormally placed neurons within the white matter of the brain. Geschwind and Levitsky (1968) proposed that the presence of these ectopias caused the delayed lateralisation of language, which had the resultant effect of impaired acquisition of reading. More recently, similar autopsy studies have also reported the presence of ectopias in the auditory cortex (Galaburda et al. 1985), the lateral area (Livingstone et al. 1991), the primary visual cortex (Jenner, Rosa & Galaburda 1999) and the cerebellum (Finch, Nicholson & Fawcett 2002).

Neurological imaging research has resulted in investigations that showed stark differences between the brain of the dyslexic and the non-dyslexic. Rumsey et al. (1992) observed decreased brain activity in 14 dyslexic adults who participated in rhyme detection and auditory detection tasks. Results revealed the subjects detected high levels of brain activity during the auditory tests, but demonstrated reduced brain activity in the left temporal lobe of the brain during rhyming tasks. Paulesu et al. (1996) performed a similar study, but examined patterns of brain activity while the subjects, of whom only half had dyslexia, performed phonological tasks and short-term memory tasks. The results revealed reduced brain activity in rhyme processing and short-term memory in the dyslexia subjects. Shaywitz (1996) and Brunswick et al. (1999) reported similar findings. Most recently, Creavin et al. (2015) claimed in a large-scale study of over 5,000 children with dyslexia that there is no link between dyslexia and visual problems. Many dyslexics report that the use of coloured overlays and coloured glasses aid their reading of black text on white paper, described as Irlen syndrome, whereby individuals have difficulty in visual perception. However, the eyes are not the main source of the problem; rather, the problems are caused by the way in which the brain interprets the visual information that is being sent through the eyes (Irlen 2017).

Due to the rise in neurological imaging technology in recent years, as well as evidence from autopsies of individuals with reading disabilities, a wide body of evidence linking dyslexia and brain function now provides us with clear anatomical and physiological differences present in the brains of those who have dyslexia (Rumsey et al. 1992; Paulesu et al. 1996). Beaton (2004) strongly suggested that neuroimaging would indicate some processing abnormality in posterior temporal-parietal areas and perhaps in the left hemisphere of dyslexics. Evidence indicating the presence of a difference in

brain function in such individuals might provide an unequivocal link between dyslexia and brain function. However, it is argued that not every individual who has dyslexia receives neurological imaging investigations upon diagnosis. Therefore, there can be no 100 per cent certainty that every person who presents with characteristics of dyslexia has evidence of such differences in brain function.

## **2.6 Societal View of Dyslexia**

Much of the literature on dyslexia in the form of academic articles begins by providing a broad definition, listing a range of associated difficulties including spelling, reading, writing and organisational skills. These definitions, despite being broad, use similar terms to those in previous literature including one or more of the listed difficulties, by many researchers of dyslexia (Thomson & Watkins 1998; Frith 1997; Elliott & Grigorenko 2014). There is a general agreement that these difficulties characterise dyslexia. However, as stated by Snowling (2000: 1) 'reading is a skill highly valued by society and in most communities holds the key to education'. Similarly, Brunswick (2012) argued that the difficulties dyslexics face result from the structures and mores of society rather than a deficit in the person. This suggests society appears to hold the concept of intelligence and effective literacy in high regard and individuals who have dyslexia, and thus have some difficulty in these skills, are seen by some in a somewhat lesser light. Foucault (1980) identified specific definitions of literacy as a dominant discourse in defining intelligence and academic ability. Therefore, 'the question arises is this discourse strongly intertwined with dyslexia because of the literacy difficulties those with dyslexia face and society's emphasis upon literacy, academic ability and intelligence?

The term 'disablism' was first coined from the social model of disability in which everyday practices of society members, including those in education, may perpetuate oppressive structures upon those who identify or are categorised as being disabled (Madriaga 2007). The underlying theme of disablism is that society produces and reproduces disability (Oliver 1990; Barnes 1991). Disablism is considered similar to the idea of institutional racism (MacPherson of Cluny 1999; Ahmad 2000), in that, individuals and/or institutions may 'unwittingly' discriminate against people who deviate from 'the norm'. This comparison to racism might be viewed as extreme. However, those who have dyslexia have certainly experienced discrimination. With a focus upon higher education (HE), rather than society in general, a number of studies have explored the attitudes of lecturers towards students with dyslexia. Cameron and Nankoosing (2012) explored lecturers' perspectives of dyslexia and dyslexic students within one university faculty in the UK and found that out of the 13 participants, two were described as having negative attitudes, specifically dismissing the existence of dyslexia. Other studies that have explored the experiences of dyslexic students have identified similar attitudes amongst teaching staff (Morgan 2001; Riddell and Weedon; 2006).

It is suggested that there has been increased awareness of dyslexia in society in recent years with influences, for example, from the Equality Act (2010), the widening participation agenda of universities and colleges, and the disclosure of dyslexia from celebrities resulting in an increased understanding of what dyslexia is and how it impacts the individual. Fitzgibbon and O'Connor (2002) suggested there has been an acceleration of interest in dyslexia over the past 10 to 15 years and the word 'dyslexia' is now part of everyday language. However, as the preceding discussion has already

highlighted, there remains a lack of understanding about dyslexia with some even dismissing its existence, specifically within HEIs. There is a large body of research surrounding the experiences of those with dyslexia within HE and further education (FE) institutions (Holloway 2001; Morgan 2001; Mortimore & Crozier 2006; Riddell & Weedon 2006; Hanafin et al. 2007; Madriaga 2007), which will be discussed in detail in Chapter 3, the literature review. However, there are lesser amounts of research focusing upon the workplace, leading to a greater reliance upon the anecdotal evidence of individuals' negative reactions to their dyslexia.

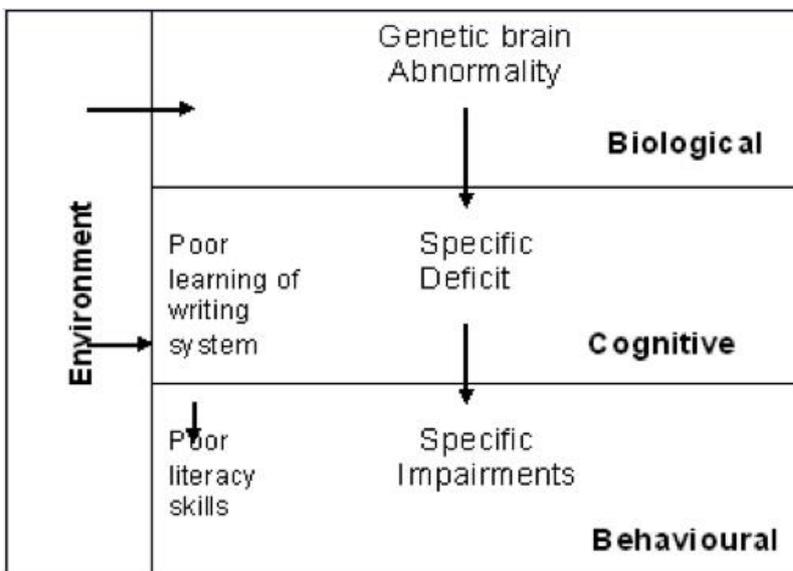
## **2.7 The Shared Theoretical Framework of Dyslexia**

This chapter has presented many different perspectives of dyslexia, from a historical context through to exploring the arguments over definition, neurological evidence and societal views surrounding dyslexia. Each of these has presented a number of contrasting views of dyslexia from many disciplines, which overall highlights how dyslexia is a subject of both contention and contrasting opinions, with no universally agreed position. In recognition of this '... there is a need to consider, given the wide range of presentations of dyslexia, how these differences could be viewed singularly in a shared schema, rather than separately as outlined in this chapter.

I first considered Frith's framework when I came upon it in an early literature search surrounding dyslexia. What drew me towards it was the use of environment, which appeared to influence the differing aspects, especially cognitive and behavioural. I found this of particular interest as I was aware of the significant impact a clinical environment could have upon dyslexic nurses through fear of disclosure of dyslexia

and negative attitudes from some. I then began to explore it further and consider how it might be of use to my study.

Frith (1995) presented a shared framework of dyslexia in an attempt to consider and account for the differences of what she described to 'bring order into the chaotic world of reading problems/dyslexia/learning disability' (Frith 1995: 6). Frith (1995) presented three key elements that surround dyslexia, namely biological, cognitive and behavioural. The biological level includes neurological brain functioning as well as the genetic basis and thus the familial link to dyslexia. The cognitive level considers the underlying causes of poor reading performance including phonological deficits, but also includes emotional factors. The behavioural level considers observation of the difficulties in learning to read and write, such as poor literacy skills. However, alongside all of these elements are environmental influences, which may impact and influence all of these three, whether this be teaching or societal attitudes for example. Frith's framework is presented in Figure 2.1:



## Figure 2.1 – Frith’s Dyslexia Framework

This framework offers some value to my study as it encompasses many of the considered elements in dyslexia and presents them as a visual shared view, rather than a range of separate contrasting components. Additionally, the framework allows an ability to direct and signpost differing causes, deficits and impairments as well as to consider environmental influences. In the context of my own study, Frith’s framework provides a basis for viewing and characterising perspectives of the nurse with dyslexia. For example, difficulties (behavioural); the emotional impact and subsequent fear of disclosure of dyslexia (cognitive); outside influences such as the university or clinical environment and those who support them in these environments (environment); as well as types and varying degrees of dyslexia (biological). The framework also assists in attempting to add context to the multi-perspectives of the nursing student/nurse with dyslexia.

As previously highlighted, one of the most significant elements of Frith’s framework to my own study is the environment, which overlaps into the biological, cognitive and behavioural portions of the framework; this highlights its importance and overall significance. The environment is particularly significant to the nurse with dyslexia, as it is this clinical workplace or university environment in which they work and interact that may potentially be influenced by the interactions and actions that occur there. Early exploration of the existing literature surrounding dyslexia and nursing identifies the strong influence of the mentor on the nursing student with dyslexia. The evidence shows how either a negative or positive reaction by mentors to dyslexia can impact upon a nursing student’s feelings and overall acceptance or lack of it within a clinical

work environment (Illingworth 2005; Morris & Turnbull 2006, 2007a, 2007b; Price & Gale 2006; Crouch 2008; Ridley 2011; Sanderson-Mann et al. 2012). Additionally, the variety of literacy difficulties as well as difficulties in memory and organisational difficulties that nursing students/nurses with dyslexia experience in clinical practice can be related, potentially, to the cognitive and behavioural elements of Frith's framework. Therefore, the framework provides a basis for the comparative theoretical elements of aspects of my study, specifically the environmental work influences as well as the literary and cognitive difficulties experienced by nurses with dyslexia. Further reference to this framework will be made in subsequent chapters.

## **2.8 Chapter Summary**

This chapter has presented an overview of dyslexia with a specific focus upon a number of areas. Firstly the historical context, secondly the defining of dyslexia as well as its variable presentation, thirdly current public policy and legislation surrounding dyslexia, fourthly the neurological basis of dyslexia and the societal view of dyslexia concluding with Frith's shared framework, which attempts to encompass some of the key elements surrounding dyslexia as well as adding context to my own study. A number of these subjects will be further discussed in greater depth in subsequent chapters. It can be summarised from the chapter that dyslexia is a subject of great depth and breadth as well as contention. The following chapter (Chapter 3) considers dyslexia with a specific focus upon nursing and presents a systematic review of the literature in the context of this area of study.

## **CHAPTER 3: Literature Review – Dyslexia in Nursing**

### **3.1 Introduction**

As highlighted in the introduction and Chapter 2, dyslexia remains a much debated and frequently contested concept within disability research and literature, even over its very existence. Within higher education (HE), where nurse education is now established in the UK, the experiences of the dyslexic student are diverse due to the vast variance and presentation of dyslexia. The purpose of this chapter is to explore current and past literature surrounding dyslexia in nursing, and present a critical and analytical discussion of this literature and how this might impact and influence my own study. The chapter will present a background of the historical development of nurse education in the UK through to the present day, to place nurses with dyslexia into context in respect of the requirement of all nursing students to achieve standards of clinical competence.

### **3.2 Literature Review Purpose**

The main purpose of a review of the literature is 'to analyse ideas, find relationships between different ideas....' (Hart 1998: 1), but should be made up of the relevant studies and knowledge that address the subject area (Cronin et al. 2008). Literature is a resource that tells us something about a topic or subject area, but Punch (2000: 42) takes this simple description further by describing literature as a 'storehouse of knowledge and thinking about a topic or area'. This thinking is significant, in that, it is the thinking as well as the analysis that occurs within research that present new ideas, theories and insights that may not have been considered before, rather than saying

something is so simply because we know it is. If we ask why it is the way we say it is and how it is that, then we delve and probe deeper into a subject or topic, which is what, we assume, occurs within research literature. However, empirical research studies are only one part of what can be defined as literature.

Thomas (2009) described categories of literature or data separating them into primary and secondary data. A primary source of data represents the first presentation or the first analysis of the data and the secondary source represents a second look, usually by someone other than the author (Thomas 2009: 31). In this respect, primary data can be characterised as research articles, diaries, autobiographies, government documents or anything that is written first hand by an author, rather than something referred to in a secondary source, such as a literature review or cited within a textbook. The literature review chapter in this thesis includes the analysis of both primary and secondary data, specifically empirical research studies that have explored the topic of dyslexia and nursing, official documents from the Nursing and Midwifery Council (NMC), the Department of Health, acts of legislation referring to disability law, as well as secondary data from literature reviews and textbooks. Collectively this literature presents a comprehensive review of a body of evidence surrounding dyslexia and nursing and any secondary or supplementary evidence, which might provide additional supporting evidence surrounding this topic. The following list presents a timeline of the three phases of literature search for this study identifying three key points of the literature search between 2012 and 2016.

- Literature Search 1 – September 2012
- Literature Search 2 – June 2015
- Literature Search 3 – February 2016

### **3.2.1 Literature Search 1**

I first began the process of searching the literature during September 2012 by undertaking a systematic search. Thomas (2009: 34) defined a systematic search or approach as using 'particular methods to search for research on a topic in a wide range of peer reviewed sources'. However, this search also included 'grey literature', such as letters and opinion pieces to consider an overview of opinions, views and perceptions surrounding dyslexia and nursing. The University of Birmingham (UoB) database was adopted to undertake the first search. No limits were set on year of publication to allow a broader view of the body of research in this area. The UoB database identified a specific list of search engines and source collections accessed in this initial search, listed as follows:

- ProQuest Nursing and Allied Health Source
- Scopus (Elsevier)
- House of Commons Parliamentary Papers (ProQuest)
- Medline/PubMed (NLM)
- ProQuest Social Sciences Premium Collection

This search was undertaken using the key words 'dyslexia' and 'nurses'. I already possessed knowledge of key research studies surrounding dyslexia and nursing from my MA thesis, which explored dyslexia amongst nursing students, as highlighted in the introduction. Additionally, I am a member of the Disability in Professional Practice Special Interest Group, made up of a group of nurse academics based in both the UK

and Irish Republic who have an active research interest in nursing students and nurses with disabilities including dyslexia. This membership provided me with direct access to a number of researchers who had undertaken research in this topic area; therefore, I already had an acquired knowledge of specific and ongoing research in this area. However, despite this acquired knowledge, there was a need for a more detailed systematic review. This initial search resulted in identification of 105 sources of which 12 were empirical research articles, 11 UK-based with one from the US. These explored specifically nursing students and/or nurses with dyslexia as listed in Table 3.2 in chronological order with the earliest publications first. Inclusion and exclusion criteria were used in relation to what sources were accessed from the initial literature search and which sources were excluded; this is outlined in Table 3.1:

**Table 3.1 – Literature search inclusion and exclusion criteria**

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Published in the English language	Published in a foreign language
Subject of nursing and dyslexic adults and other healthcare disciplines	Studies exploring dyslexia and children
Articles, books and general publications	
No limits on publication date	

**Table 3.2 – List of nursing and dyslexia articles identified in initial literature search 1**

Title and Citation	Author
1. 'Helping the dyslexic nursing student' (1993) <i>Nurse Educator</i> , 18(6): 10-13 (US article)	Shellenbarger, T.
2. 'Educational support for nursing and midwifery students with dyslexia' (2000) <i>Nursing Standard</i> , 14(41): 35-41	Wright, D
3. 'The effects of dyslexia on the work of nurses and healthcare assistants' (2005) <i>Nursing Standard</i> , 19(38): 41-48	Illingworth, K.
4. 'Understanding dyslexia and nurse education in the clinical setting' (2005) <i>Nurse Education in Practice</i> , 6(3): 127-133	Sanderson-Mann, J., McCandless, F
5. 'Clinical experiences of students with dyslexia' (2006) <i>Journal of Advanced Nursing</i> , 54(2): 238-247	Morris, D., Turnbull, P.
6. 'How do dyslexic nursing students cope with clinical practice placements? The impact of the dyslexic profile on the clinical practice of dyslexic nursing students: Pedagogical issues and considerations' (2006) <i>Learning Disabilities</i> , 4(1): 19-36	Price, G.A., Gale, A.
7. 'A survey-based exploration of the impact of dyslexia on career progression of UK registered nurses' (2007b) <i>Journal of Nursing Management</i> , 15(1): 97-106	Morris, D., Turnbull, P
8. 'The disclosure of dyslexia in clinical practice: Experiences of student nurses in the UK' (2007a) <i>Nurse Education Today</i> , 27(1): 35-42	Morris, D., Turnbull, P
9. 'Supporting nursing students with dyslexia in clinical practice' (2007) <i>Nursing Standard</i> , 21(19): 35-42	White, J.
10. 'The experiences of nursing students with dyslexia' <i>Nursing Standard</i> , (2011) 25(24): 35-42	Ridley, C.
11. 'Exploring the learning experiences of nursing students with dyslexia' <i>Nursing Standard</i> , (2011) 25(40): 39-46	Child, J., Langford, E
12. 'An empirical exploration of the impact of dyslexia on placement-based learning and a comparison with non-dyslexic students' (2012) <i>Diversity and Equality in Healthcare</i> , 9(2): 89-99	Sanderson-Mann, J., Wharard, H.J., McCandless, F.

This search also identified a number of letters and news reports detailing non-dyslexic nurses' views and opinions of dyslexia, as well as dyslexic nursing students' personal experiences of their own dyslexia. These for the most part were published in the *Nursing Standard*, a UK-based professional nursing journal. Such resources are described as 'grey literature', which can be comprised of theoretical texts, opinion pieces and newspaper reports (Cleaver et al. 2014).

It was noted amongst this initial search, two additional articles by Murphy were identified, which explored dyslexia amongst radiography students and healthcare students.

- Murphy, F. (2008) 'The clinical experiences of dyslexic healthcare students.'  
*Radiography*, 15(4): 341-344
- Murphy, F. (2011) 'On being dyslexic: Student radiographers' perspectives.'  
*Radiography*, 17(2): 132-138

I considered that these two articles might add further perspectives to the topic surrounding the wider population of healthcare students with dyslexia, indicating potential similarities or contrasts to dyslexic nursing students.

A second further search of alternative databases not listed on the UoB database, namely Google Scholar and sciencedirect.com was undertaken, again using the same keywords 'nurses' and 'dyslexia' used in the initial search. This search also identified the same articles listed in Table 3.2. However, from this search one literature review study was identified as well as two further empirical research studies by the same author:

- Aiken, F. Dale, C. (2007) *A review of the literature into dyslexia in nursing practice*. Royal College of Nursing Practice Education Forum
- Crouch, A. (2010) 'Experiences of non-dyslexic and dyslexic nursing and midwifery students: How best can their needs be met by personal academic tutor support?' *Enhancing the Learner Experience in Higher Education* 2(1): 56-72
- Crouch, A. (2008) *Needs/experiences of dyslexic students and support in clinical practice*. The University of Northampton. Funded by the Higher Education Academy for Health Sciences and Practice  
<http://www.health.heacademy.ac.uk/rp/publications/projectreports/summaries/acrouchexecsum.html>

Additionally, a number of US studies were highlighted that explored nursing students with either disabilities or learning disabilities. It was noted the term 'learning disabilities' or 'the learning disabled' was used in these articles to describe an individual with dyslexic characteristics, but not actually using the term 'dyslexia'. However, these studies were also included in the literature review:

- Eliason, M.J. (1992) 'Nursing students with learning disabilities: Appropriate accommodation.' *Journal of Nursing Education*, 31(8): 375-376
- Tumminia, P.A., Weinfield, A.M. (1986) 'Survival strategies for the learning disabled student.' *Nurse Educator*, 2(4): 321-324
- Watson, P.G. (1995) 'Nursing students with disabilities: A survey of baccalaureate nursing programs.' *Journal of Professional Nursing*, 11(3): 147-153

### **3.2.2 Literature Search 2**

I performed a further systematic search during June 2015 again, using the UoB database. This was following a short break in my studies due to personal circumstances. As in the previous search, keywords included were 'dyslexia' and 'nurses'. This second search resulted in 120 sources derived from the same search engines and source collections as previously highlighted. The same articles identified in Table 3.2 were present in this second search; however, two further studies surrounding nursing students and dyslexia listed in Table 3.3 were identified (Evans 2014a, McPheat 2014), one from the UK, two by the same author from the Irish Republic. A further check of the literature in October 2015, undertaken to identify any previously overlooked articles, revealed one study from Japan (Ikematsu et al. 2014) and a study by Evans (2015) on disclosing a dyslexic identity. The UK study by McPheat (2014) was a literature review of dyslexia in nursing rather than an empirical study. Literature reviews are clearly not empirical research studies, but provide an overview of current research in an area of specific interest and may often give insights into new research and/or information not known to the reader.

**Table 3.3 – List of additional nursing and dyslexia articles identified in June 2015 literature search 2**

Title and Citation	Author
1. Disclosing a dyslexic identity <i>British Journal of Nursing</i> (2015), 24(7) 383-385	Evans, W.
2. Nursing students with special educational needs in Japan. <i>Nurse Education In Practice</i> , 14 (2014) 674-679	Ikematsu, Y. et al.
3. 'If they can't tell the difference between duplelac and digoxin, you've got patient safety issues'. Nurse lecturers constructions of students dyslexic identities in nurse education <i>Nurse Education Today</i> , 34 (2014b) 41-46	Evans, W.
4. Experiences of nursing students with dyslexia on clinical placement. <i>Nursing Standard</i> , (2014) 28 (41) 44-49	McPheat, C.
5. 'I am not a dyslexic person I'm a person with dyslexia:' identity constructions of dyslexia amongst students in nurse education. <i>Journal of Advanced Nursing</i> , (2014a) 70(2) 360-372	Evans, W.

On this second search in June 2015, I searched the literature again but changed the keywords to 'dyslexia' and 'nursing' instead of 'nurses' as previously used. This search resulted in 1,304 sources. Sifting through these sources, no new research articles surrounding nurses and dyslexia were identified. This search appeared to identify sources that had explored or talked about dyslexia per se, resulting in the larger output of sources.

The studies listed in Tables 3.2 and 3.3 can be described as core studies or core works. Hart (1998: 39) described core works as 'those which have had a major influence methodologically and morally and which have fostered cross-disciplinary work'. The subject of dyslexia and nursing is a limited area of research with currently only 24 studies that exclusively and specifically explore the experience of the nurse with dyslexia or learning disability, dependent upon what language is used. This would

suggest this area of research is limited not only in terms of its quantity of studies but also in that a gap exists that potentially has a need for further exploration and development.

### **3.2.3 Literature Search 3**

A third literature search was undertaken in February 2016 specifically to identify evidence of any more US research studies surrounding dyslexia and nurses. Three US studies on this subject had previously been identified in literature search 2 (Tumminia & Wienfield 1986, Eliason 1992, Watson 1995). However, as previously noted, these studies did not use the term dyslexia; rather, the terms 'learning disability' or 'learning disabled' were used, which indicated a different use of language between the UK and US when describing what we know as dyslexia. Therefore, these terms were used as key words in this literature search to assist in identifying further US literature.

The UoB database was again used as in previous literature searches 1 and 2, using the same search engines and source collections listed in section 3.2.1., as well as the same inclusion and exclusion criteria outlined in Table 3.1. The terms 'learning disability' and 'learning disabled' were used as key words accompanied by 'nurses' and 713 sources were returned. However, these appeared to be articles and papers focusing upon patients or people with learning disabilities, or nurses working in the field of learning disability that identify with the associated UK term. I then added the word 'dyslexia' to the search terms. This search returned 18 sources, but the articles found were, for the most part, the same studies identified in literature searches 1 and 2.

Following this search, I then typed in 'nursing education programs learning disabilities', which matched part of the content and titles of the three US studies identified in

literature search 2. This returned 369 sources. However, despite that, a larger majority of this number was not relevant; two relevant US studies were identified as follows:

- Ijiri, L., Kudzma, E.C. (2000) 'Supporting nursing students with learning disabilities: A metacognitive approach.' *Journal of Professional Nursing*, 16(3): 149-157
- Colon, E.J. (1997) 'Identification, accommodation and success of students with learning disabilities in nursing education programmes.' *Journal of Nursing Education*, 36(8): 372-377

These two studies explored nursing students with dyslexia from the context of the classroom environment rather than the clinical environment. It is notable to recognise that following this third literature search, there appears to be no evidence of any US studies after the year 2000 that specifically explore learning disabilities in nursing students. It might be surmised that this is an under-researched area of study in the US. Further discussion and analysis of these studies will follow in the subsequent sections of this chapter.

### **3.3 Key findings and Discussion of Core Studies**

The research studies highlighted in Tables 3.2 and 3.3 are not identical in the area of dyslexia and nursing they have each explored; despite that, a number of the titles of these studies are quite similar. Each individual study has something to contribute to this area of research and body of evidence. Table 3 in Appendix 1 breaks down their specific findings and outlines what they contribute to the body of evidence surrounding dyslexia and nursing. However, these studies come from a range of publication dates specifically from 1993 until 2014, a period of 21 years. It is important to note the

relevance of earlier published research in relation to recent legislation and public policy surrounding disability. For example, the Disability Discrimination Act did not become law until 1995. Therefore, any disability research published prior to this date would not consider the influences of this legislation. Similarly, educational institutions or workplaces prior to 1995 were not required by law to either support or employ persons with disabilities, thus any disability related research in these areas would again be influenced by current times and thinking.

As previously highlighted in section 3.3.3, a search of the literature revealed some early research from the US surrounding learning disabilities from 1986 onwards, a term commonly used in the US to describe conditions such as dyslexia:

- Tumminia, P.A., Weinfield, A.M. (1986) Survival strategies for the learning disabled student. *Nurse Educator*, 2(4): 321-324
- Eliason, M.J. (1992) Nursing students with learning disabilities: Appropriate accommodation. *Journal of Nursing Education* 31(8): 375-376
- Shellenbarger, T. (1993) Helping the dyslexic nursing student. *Nurse Educator*, 18(6): 10-13
- Watson, P.G. (1995) Nursing students with disabilities: A survey of baccalaureate nursing programs. *Journal of Professional Nursing*, 11(3): 147-153

Two of these studies, Eliason (1992) and Watson (1995), both highlighted the US disability legislation, specifically the Rehabilitation Act (1973) and the Americans with Disabilities Act (1990), which included educational institutions. In referring to the passing of these Acts, both studies suggest these had a resultant effect of an

increasing number of young adults with disabilities entering colleges and universities. These acts of legislation were not presented as a direct prompt or justification for the studies, but the highlighting of this legislation at the very beginning is significant in providing a starting point to the background of these studies. The study by Ikematsu et al. (2014), which explores nursing students with special educational needs in Japan, highlighted an amendment in Japanese law, which made it illegal for nursing schools in Japan to reject students based on their disabilities. It could be argued that, as a direct result of UK disability legislation, UK universities were obliged to meet the requirements of legislation, which then had an impact in raising awareness amongst academic and support staff of university students with disabilities, resulting in the subsequent number of research studies.

Collectively this disability legislation and subsequent awareness suggests two possible prompts for a rise in research surrounding dyslexia and nursing in the UK from 2000 onwards. UK disability legislation came into being with the passing of the Disability Discrimination Act (DDA) (HMSO 1995), which made it unlawful for an employer to discriminate against a disabled person in the field of employment. The Special Educational Needs and Disability Act (SENDA) (2001) extended the DDA to make it unlawful to discriminate against pupils and students in education. It is notable, therefore, as identified in Table 3.2, that the earliest UK study that explored dyslexia and nursing was Wright (2000) and a significant amount of research on this subject followed after this study (see Appendix 1).

The experiences of nursing students with dyslexia were explored in many of these studies as well as a smaller number exploring the experiences of registered nurses

with dyslexia. These experiences in the majority of cases were from the perspective of the clinical practice area. However, a lesser number of these studies were singularly from the university environment. An overview of these studies shows some similarities in their findings, particularly the difficulties voiced by the nursing students/nurses with dyslexia. Five common difficulties experienced by nursing students and nurses were noted across a number of the studies:

1. documentation, such as difficulty in spelling certain words and taking more time over documentation;
2. drug administration, specifically double or triple checking prescription charts and drug bottles to ensure correct drug administration;
3. communication skills, such as organising thoughts prior to communicating within a clinical handover or doctors' round;
4. time management, specifically organising their time during the duration of a clinical shift; and
5. memory difficulties, such as remembering to do a specified list of tasks or recalling facts for a clinical handover

(Illingworth 2005; Sanderson-Mann & McCandless 2005; Morris & Turnbull 2006, 2007a; White 2007; Crouch 2008; Ridley 2011; Sanderson-Mann & Wharard 2012).

The difficulties noted by these studies demonstrate a commonality amongst the dyslexic nursing students/nurses, but also at the same time a disparity in that not every student presented with the exact same difficulties. For example, not all dyslexic nurses are poor readers (Shepherd 2002). This adds support to the discussion on the variance of the presentation of dyslexia in Chapter 2, specifically Rose (2009) and Riddick

(2010) describing dyslexia as a continuum and Snowling (2008) stating that dyslexia should be considered as a dimension rather than a category. Additionally, the description of co-occurring difficulties, which can occur as part of a dyslexia pattern (Rose 2009), gives further credence to the variability of difficulties the nursing students presented with. Further exploration of these studies also revealed not only differences in difficulties experienced, but also different perceptions of what it means to be a person with dyslexia.

A detailed and in-depth analytical discussion of specific aspects of these studies follows, which includes focusing upon key themes particularly on nursing students and registered nurses with dyslexia both at university and in practice.

### **3.4 Dyslexia in Nurse Education**

This section explores the evidence from the results of the literature search surrounding dyslexia in nurse education. This section will open with a discussion of the historical development of nurse education in the UK up to the present day, placing into context the subject of dyslexia in nurse education.

#### **3.4.1 The Development of Nurse Education in the UK**

Nurse education in the UK has undergone a number of significant changes over the last 30 years. From a historical perspective, the training of nurses in the UK was first established in 1860 with the opening of the Nightingale Training School at St. Thomas' Hospital in London, one of the first institutions to teach nursing and midwifery as a formal profession (Thomas 2016). This resulted in a number of other nurse training schools opening around the UK. These hospital-based nurse training schools

continued throughout the nineteenth and twentieth centuries and continued following the advent of the National Health Service (NHS) in 1948.

The Briggs Report (1972), which reviewed the role of the nurse in the hospital and community, resulted in the passing of the Nurses, Midwives and Health Visitors Act (1979), marking a decisive break in nursing with the establishment of the apprenticeship model of nursing (Bradshaw 2001). The apprenticeship model placed much reliance upon experience gained in the clinical setting (traditionally the hospital) as a means of acquiring knowledge and skills (Glen 1999). Additionally, the Act also established the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), a statutory body concerned with basic and post-basic nurse training in Great Britain (Ousey 2011), which was the precursor to the present day NMC

In 1985, a gradual move away from the apprenticeship model began with the Judge Report – RCN Commission on Nurse Education (1985), which recommended the transfer of nurse education into higher education (HE) institutions. This resulted in the movement away from hospital-based schools of nursing and a call for a broader nursing curriculum. It was a gradual development and only began in the late 1980s. It was also accompanied by Project 2000, a very different nursing curriculum, which encompassed a one-year foundation, a second year in adult nursing and a third year in a specific nursing speciality. However, a decade later concerns were raised that Project 2000 was failing to develop practice knowledge and skills amongst students and the nursing curriculum was overly theoretical, particularly at the beginning of the programme (Taylor et al. 2009).

The Peach Report (UKCC 1999), driven by these concerns of failing to develop practice knowledge and skills amongst nurses, was commissioned to address these concerns. One of its key recommendations was to make nursing more practically based, away from the more theoretical focus of Project 2000. This recommendation for a more practical focus on nursing was further reiterated in the DoH (1999) *Making a Difference* document, which set out a need for nursing programmes to demonstrate a greater practical foundation, with more emphasis placed upon clinical practice placements and the achievement of clinical competencies. The Peach Report (UKCC 1999) additionally called for wider access to nursing and that entry requirements should be more flexible, encouraging students from a broader range of backgrounds. The resultant impact of this aspect of the Peach Report saw a seven-fold increase in the number of nurses entering nursing courses (Watson et al. 2005).

In 2006, all governments of the four UK countries collectively set out a policy blueprint for all UK registered nurses. Modernising Nursing Careers (DoH 2006) was considered to be one of the most radical and important initiatives in recent years (Taylor et al. 2009). It set out priorities for nursing in four key areas:

- A competent and flexible workforce
- Updated career pathways
- Preparation of nurses to lead a changed healthcare system
- Modernising the image of nursing and nursing careers

Alongside these changes witnessed the advent of advancing clinical roles for nurses. Even though specialist-nursing roles were nothing new, such roles were evident in the 1950s through to the 1990s in the UK and advancing practice for nurses emerged in the US in the early part of the twentieth century. Advancing clinical roles for nurses were defined as where a registered nurse is working at a level well beyond their registration using their existing knowledge and skills to inform and further develop their practice (Health Education England 2016). These new advancing roles also called for a dedicated career pathway where higher level qualifications such as master degrees and professional doctorates were required to advance into such roles.

A further significant development in nurse education came in 2009 when the Nursing and Midwifery Council (NMC) announced that by 2013 the minimum academic award for all undergraduate nursing programmes would be a degree. This established nursing as an all degree profession. The rationale for this historic move announced by the government was a need for nurses to deliver high quality care. Additionally, it was considered as a key action to modernise further the nursing profession (DoH 2008). Although undergraduate nursing courses were based within universities, one of the key differences to other university degree programmes was that nursing students were not required to pay tuition fees; rather, they received a means tested NHS bursary. However, it was announced by the Conservative government in November 2015 that bursaries would be withdrawn and all nursing students commencing an undergraduate

nursing degree from September 2017 would receive a loan to pay their course tuition fees. This change received wide criticism from a number of professional bodies including the Royal College of Nursing (RCN) and the British Medical Association (BMA) raising concerns that such a move would be an 'untested gamble' and threaten existing NHS staff shortages (Guardian 2016). More recently, it was reported that applications to nursing and midwifery courses in England fell by 23% following the government's move to abolish bursaries (Guardian 2017).

The historical overview of nursing presented in this section places in context the development of the training and education of nurses from the nineteenth through to the twenty-first century. More specifically, it has highlighted the emphasis placed upon clinical competence in practice within current nurse education and the requirement of nursing students to develop both skills and knowledge and the fulfilment of such competencies in clinical practice. Clinical competence in relation to dyslexia and nursing will be discussed in section 3.6.3.

### **3.4.2 Dyslexia in Higher Education**

Riddell et al. (2005a) noted that prior to 1993 higher education was largely inaccessible to disabled people. In 1993, the creation of Skill (the National Bureau for Students with Disabilities), a voluntary organisation that promoted access to HE for disabled people, resulted in universities becoming more accessible to disabled students. The advent of the 1995 Disability Discrimination Act (HMSO 1995) and the subsequent Equality Act (2010) required universities meet their legislative responsibilities that disabled students were not discriminated against and reasonable adjustments be put in place to ensure a student with a disability could be accommodated within the university learning environment.

The number of UK entrants to full-time first-degree courses with a known disability was 44,250 in 2015/16, which was an increase of 56 per cent since 2010/11 (HEFCE 2017). Specific learning difficulties such as dyslexia consistently make up around half of all self-reported disabilities in HE (HEFCE 2016). Dyslexia is the most frequent self-declared disability in HE in the UK (Mortimore & Crozier 2006). The incidence of students with disclosed dyslexia entering HE has significantly increased over the past 17 years. In 2000/01, there were 10,430 students with dyslexia at UK universities in their first year (HESA 2002). This figure had risen to 19,740 in 2005/06 (HESA 2008), 74,490 in 2007/8 and 104,580 in 2012-13. Between the years 2000 and 2004, figures from HESA showed the number of dyslexic students entering university increased by almost 100% (HESA 2008). However, it is believed that this figure could be significantly higher and will only represent those who have declared they are dyslexic on university admission or those who are aware that they have dyslexia. Singleton (1999) noted that up to 43% of the dyslexic university population are not diagnosed until after admission to their respective programme. In addition, a large percentage of adults with dyslexia remain undiagnosed (Dyslexia International 2014); therefore, the HE dyslexia percentages quoted, can be predicted to be much higher, if this undiagnosed population are taken into account.

The Special Educational Needs and Disability Act (2001) extended the Disability Discrimination Act (HMSO 1995) to HE institutions, which made it unlawful to discriminate against disabled students in the application, admission and enrolment process, and provided an impetus for universities to review their disability policies and practice (Mortimore & Crozier 2006). Richardson and Wydell (2003) argued that students might choose not to reveal to their institutions that they are dyslexic, despite

the introduction of the disability legislation to protect them. Tinklin and Hall (1999) suggest the possibility that students seeking access to HE might not disclose a disability, lest doing so might prejudice their admission. Therefore, the question is raised as to whether, despite the presence the current Equality Act (2010) legislation, there remains hesitancy amongst dyslexic students in disclosing their dyslexia in HE. In addition, more significantly, whether there is evidence of negative perceptions and prejudice towards dyslexic students in the HE arena. The issue of the disclosure of dyslexia will be discussed in further detail in section 3.5.5.

A number of studies have explored the experiences of students with dyslexia in HE. It has been found that academic staff often appeared too busy to help students with dyslexia or students with disabilities (Holloway 2001; Mortimore & Crozier 2006). Additionally, some staff were perceived as dismissive, cynical, patronising or rude to students with regard to dyslexia (Hanafin et al. 2007, Madriaga 2007). However, this cannot be generalised to all university staff or all UK universities as other studies have reported positive and supporting attitudes towards students with dyslexia (Cameron & Nunkoosing 2012; Evans 2014; Atabey 2017).

A study by Cameron and Nunkoosing (2012) explored the experiences and perspectives of university lecturers surrounding dyslexia and dyslexic students at one UK University. It revealed that eight of the 13 participants had positive attitudes towards dyslexia and students with dyslexia and demonstrated both an understanding of their difficulties and sympathy towards them. Three of the participants in the study were categorised as having a neutral attitude as they expressed a vague idea of dyslexia, and did not share any particular opinions about dyslexia or students with dyslexia. Two

participants in the study were categorised as having negative attitudes, as they showed little understanding of either the strengths or difficulties experienced by dyslexic students at university and at times doubted the existence of dyslexia.

A study by Evans (2014) explored nurse lecturers' constructions of students' dyslexic identities in nurse education. This study showed similar findings to Cameron and Nunkoosing's study in the variability of nurse lecturers' attitudes to students with dyslexia, with some demonstrating support and understanding of nursing students with dyslexia in contrast to others demonstrating very negative attitudes. These negative attitudes were around the safety of nursing students with dyslexia, specifically over the confusion of drug names. It is argued that these negative attitudes might be a consequence of disablism, previously discussed in Chapter 2. Disablism has its origins in the social model of disability, whereby everyday practices of society members, including those in education, may perpetuate oppressive structures upon those who identify or are categorised as disabled (Madriaga 2007).

It is argued that the under-representation of disabled students in HE is a resultant factor of living in a disabilist society (Oliver 1996; Wareing & Newell 2002; Newell & Wilkinson 2003). Based on a wide body of evidence (Borland & James 1999; Holloway 2001; Fuller et al. 2004; National Disability Team & Skill, 2004; Riddell et al. 2005a), obtaining full equality of opportunity is difficult to achieve whilst pursuing HE in the UK. However, as previously highlighted, there is evidence of positive understanding and support from university teaching staff towards those with dyslexia and disability, but this collective positive outlook is by no means universal. Adams and Brown (2000) and Fuller et al. (2004) argued this continued evidence of disablism in HE is a result of disability issues

being confined within the university's student services departments rather than academic departments. However, a more recent study by Lukianova and Fell (2016) reported significant progress in making HE more accessible for people with disabilities and there are many reports of good disability practice amongst UK universities (Atabey 2017). Madriaga (2007) stated that disability legislation and quality assurance policies along with university disability policies would go some way to addressing disablism throughout the HE environment.

In addressing disablism, there has emerged a recent drive to introduce inclusive teaching and learning in HE, including nurse education. Inclusive teaching and learning is an approach that takes into account students' educational, cultural and social background and experience, as well as the presence of any physical or sensory impairment and their mental well-being. It enables HEIs to embed quality enhancement processes that ensure equality in teaching and learning (Morgan & Houghton 2011). Croucher and Romer (2007: 3) described the inclusive approach thus: '... [it] does not place groups in opposition to each other. It respects diversity but does not imply a lack of commonality; it supports the concept of widening participation...'

The inclusive approach was in response to concerns that a student's gender, race and disability affects their experience at university and the shift away from supporting individual learners through disabled student allowance (DSA) (Government UK 2017). The previous approach to students with disabilities is less inclusive and compensates through making special provisions and adjustments. Inclusive teaching and learning is not a new concept and has been considered in recent years with emerging awareness of disabilities within education, as well as the advent of UK disability legislation and the

increasing numbers of disabled students into HE (Adams & Brown 2006; Healey et al. 2006; Hockings 2010). However, Adams and Brown (2006) stressed that for most HEIs, this would require a significant cultural shift, from seeing disabled students as 'outsiders coming in' to an institution that openly embraces 'all comers'. Any future research in this area might reveal the impact and potential success of such a cultural shift in HE

### **3.5 Dyslexia and Nurses in Clinical Practice**

This section explores the literature surrounding nursing students and nurses with dyslexia, who work in clinical practice referring directly to the literature highlighted in Tables 3.2 and 3.3 and the subsequent literature searches 1-3 highlighted at the beginning of this chapter.

#### **3.5.1 Nurses with Dyslexia – Difficulties in Practice**

The RCN (2014: 3) presented a definition of nursing:

The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

Additional to this definition, the practice of nursing requires of the nurse a variety of skills including personal patient care; critical thinking; delegation; patient education; and physical, psychological, social and spiritual care (RCN 2014). All these skills require a combination of both knowledge and commitment to the values of nursing. Nursing can be both physically and psychologically demanding and stressful at times. It requires the nurse to have a wide variety of skills including clinical decision-making, accurate documenting, mental arithmetic and prioritising. Add to this the ability to retain

a vast knowledge base on clinical conditions, pharmacology, human physiology and a wide variety of patient treatment and patient management strategies.

A number of studies highlighted difficulties experienced by the dyslexic nursing student/registered nurse in clinical practice (Illingworth 2005; Morris & Turnbull 2006, 2007a; Gale & Price 2006; White 2007; Crouch 2008; Ridley 2011; Sanderson-Mann & Wharard 2012; Ikematsu et al. 2014). Firstly, it is of interest how these difficulties are described and the different terms used. The term 'difficulty' is defined by the New Oxford Dictionary (2001) as 'a thing that is hard to accomplish, deal with or understand'. One US study (Tumminia & Weinfield 1986) described how nurse educators view learning-disabled students as 'both a frustration and a challenge'. The study by Ikematsu et al. (2014), which explored the incidence and nature of nursing students with special educational needs in Japan, used the term 'extremely difficult students' to describe a percentage of nursing students with special educational needs; however, these included nursing students with ADHD and Asperger's as well as dyslexia. The language and phrases used might be described as discourses, which will be discussed later in this chapter.

Different authors have listed a range of difficulties observed amongst nurses and nursing students with dyslexia. However, there is some communality in the difficulties listed amongst the participants in each study. Table 3.4 lists these difficulties from each individual study:

**Table 3.4 – Difficulties in clinical tasks experienced by dyslexic nursing students/nurses**

Article Reference	Difficulties listed
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<p>Morris, D., Turnbull, P. (2006) 'Clinical Experiences of students with dyslexia.' <i>Journal of Advanced Nursing</i>, 54(2): 238-247</p>	<ul style="list-style-type: none"> <li>• Short term memory problems</li> <li>• Hand/eye co-ordination/manual dexterity</li> <li>• Dyscalculia (drug calculations)</li> <li>• Documentation</li> <li>• Recalling and pronouncing drug names</li> </ul>
<p>Sanderson-Mann, J., Wharard, H.J., McCandless, F. (2012) 'An empirical exploration of the impact of dyslexia on placement-based learning and a comparison with non-dyslexic students.' <i>Diversity and Equality in Healthcare</i>, 9(2): 89-99</p>	<ul style="list-style-type: none"> <li>• Clinical Handovers to other staff</li> <li>• Nursing Documentation</li> <li>• Clinical Observations</li> <li>• Drug calculations/administration</li> </ul>
<p>Child, J., Langford, E. (2011) 'Exploring the learning experiences of nursing students with dyslexia.' <i>Nursing Standard</i> 25(40): 39-46</p>	<ul style="list-style-type: none"> <li>• Short term memory problems</li> <li>• Reading/writing difficulty</li> <li>• Spelling difficulty</li> <li>• Pronunciation difficulty</li> <li>• Need for more time to complete tasks</li> </ul>
<p>Shellenbarger T. (1993) 'Helping the dyslexic nursing student.' <i>Nurse Educator</i> 18(6): 11-13</p>	<ul style="list-style-type: none"> <li>• Difficulty following directions</li> <li>• Getting items in incorrect order</li> <li>• Carrying out lengthy list of instructions</li> <li>• Difficulty with directional terms such as left and right</li> <li>• Difficulty meeting deadlines</li> </ul>
<p>White, J. (2007) 'Supporting nursing students with dyslexia in clinical practice.' <i>Nursing Standard</i>, 21(19): 35-42</p>	<ul style="list-style-type: none"> <li>• Problems with spelling</li> <li>• Slow at reading and writing</li> <li>• Reading and pronouncing unfamiliar or long or unusual words</li> <li>• Untidy handwriting</li> <li>• Poor short term memory</li> <li>• Poor concentration span</li> </ul>
<p>Ridley, C. (2011) 'The experiences of nursing students with dyslexia.' <i>Nursing Standard</i> 25(24): 35-42</p>	<ul style="list-style-type: none"> <li>• 'When reading, mixing words'</li> <li>• 'Retaining of information'</li> <li>• 'Forgetting things easily'</li> <li>• 'With background noise, I get distracted' (p.38)</li> </ul>
<p>Crouch, A. (2008) <i>Needs/experiences of dyslexic students and support in clinical practice</i>. The University of Northampton. Funded by the Higher Education Academy for Health Sciences and Practice</p>	<ul style="list-style-type: none"> <li>• Forgetfulness</li> <li>• Difficulty with spelling, grammar and writing</li> <li>• Problems with words and numbers</li> <li>• Slow at doing things</li> </ul>
<p>Morris, D., Turnbull, P.A (2007b) 'Survey-based exploration of the impact of dyslexia on career progression of UK registered nurses.' <i>Journal of Nursing Management</i> 15(1): 97-106</p>	<ul style="list-style-type: none"> <li>• Record keeping/documentation</li> <li>• Need for more time</li> <li>• Drug administration/calculation</li> <li>• Difficulty in communicating verbally</li> <li>• Poor memory/ recalling information</li> <li>• Poor handwriting</li> </ul>

Price, G.A., Gale, A. (2006) 'How do dyslexic nursing students cope with clinical practice placements? The impact of the dyslexic profile on the clinical practice of dyslexic nursing students: Pedagogical issues and considerations.' <i>Learning Disabilities</i> 4(1): 19-36	<ul style="list-style-type: none"> <li>• Word recognition</li> <li>• Spelling mastery</li> <li>• Time taken to retrieve and use language effectively</li> <li>• Handover</li> <li>• Chart keeping</li> </ul>
Ijiri, L., Kudzma, E.C. (2000) 'Supporting Nursing Students with Learning Disabilities: a metacognitive approach.' <i>Journal of Professional Nursing</i> , 16 (3): 149-157	<ul style="list-style-type: none"> <li>• Handwriting, spelling</li> <li>• Calculations</li> <li>• Organisation skills</li> <li>• Memory</li> </ul>

The difficulties listed in Table 3.4 demonstrate the wide variability in the difficulties nursing students/registered nurses with dyslexia experience in clinical practice. This further relates to the discussion in Chapter 2 where Rose (2009) spoke of co-occurring difficulties, specifically aspects of language, motor co-ordination, mental calculation, concentration and personal organisation, which can occur as part of the dyslexia pattern, but are not by themselves markers of dyslexia. Some of these co-occurring difficulties described are apparent amongst these difficulties listed in Table 3.4, thus adding further evidence to the variability of the presentation of dyslexia.

A more recent study by Crouch (2017) explored how dyslexia impacts upon twelve nursing and midwifery students. It also revealed difficulties with documentation, reading unfamiliar words, numeracy and short-term memory, which has similarities to some of the difficulties listed in Table 3.4.

The sample sizes in the studies listed in Table 3.4 were quite small, varying between seven and 18, apart from Morris and Turnbull (2007b) whose study concerning registered nurses had 116 participants who answered a postal questionnaire. These studies were all qualitative in nature, indicated by the focus upon the individual

experiences of the participants. Qualitative research is described as a form of social enquiry that focuses on the way people make sense of their experiences and the world in which they live (Holloway & Wheeler 2002: 3). As the difficulties listed in Table 3.4 indicate, dyslexia can be presented in several different ways (Shellenbarger 1993). It could be determined that one person with dyslexia will not present with exactly the same characteristics as another person with dyslexia. However, in an attempt to further categorise and organise the difficulties in Table 3.4 and to eliminate the different descriptions presented in the studies, which are often describing essentially the same difficulty, a new table is presented. Table 3.5 identifies four common difficulties identified from the data categorising the findings from the studies into these four sections.

**Table 3.5 – Categories of common areas of difficulty from study findings**

Memory	Documentation	Drug Administration	Nursing Tasks
<ul style="list-style-type: none"> <li>• Short-term memory problems</li> <li>• Forgetfulness</li> <li>• Poor memory/recalling information</li> <li>• ‘Forgetting things easily’</li> <li>• ‘Retaining of information’</li> </ul>	<ul style="list-style-type: none"> <li>• Completing and writing nursing documentation</li> <li>• Reading/writing difficulty</li> <li>• Spelling difficulty</li> <li>• Problems with spelling</li> <li>• Slow at reading and writing</li> <li>• Difficulty with spelling, grammar and writing</li> <li>• Record keeping/documentation</li> <li>• Poor handwriting</li> <li>• ‘When reading, mixing words’</li> <li>• Untidy handwriting</li> <li>• Chart keeping</li> <li>• Spelling mastery</li> <li>• Time taken to retrieve and use language effectively</li> </ul>	<ul style="list-style-type: none"> <li>• Drug calculations/administration</li> <li>• Dyscalculia (drug calculations)</li> <li>• Recalling and pronouncing drug names</li> <li>• Drug administration/calculation</li> <li>• Reading and pronouncing unfamiliar or long or unusual words</li> <li>• Word recognition</li> </ul>	<ul style="list-style-type: none"> <li>• Difficulty following directions</li> <li>• Carrying out lengthy lists of instructions</li> <li>• Slow at doing things</li> <li>• Need for more time</li> <li>• Handovers</li> <li>• Clinical observations</li> <li>• Difficulty in communicating verbally</li> <li>• ‘With background noise, I get distracted’</li> </ul>

With reference to specific difficulties experienced by dyslexics within a daily work environment, Moody (1999) related the typical problems that adults with dyslexia experience to potential effects on efficiency at work (see Table 3.6; text in bold). White (2007:36) added clinical nursing practice examples to Moody’s examples to identify a relationship to nurses with dyslexia (italic text):

**Table 3.6 – Difficulties experienced by nurses with dyslexia in practice**

- **Literacy skills** – *reading and writing reports*
- **Memory** – *remembering information or instruction, for example, in handover, doctors' rounds and case conferences*
- **Sequencing ability** – *undertaking a complex activity or procedure involving many steps*
- **Visual orientation** – *confusing left and right or up and down*
- **Hand/eye co-ordination** – *may result in poor presentation of written work or difficulty in undertaking some clinical skills*
- **Speech** – *may talk in a disorganised way, especially in meetings or on the telephone*

Findings by other researchers examining the clinical performance of nursing students with dyslexia have revealed similar difficulties. Tumminia and Weinfield (1983) found that students had difficulty articulating instructions given to them by others. Shuler (1990) found students with dyslexia were disorganised and had difficulty meeting deadlines and following directions. Shellenbarger (1993) found students had problems following directions and placed items in an incorrect order, especially if there was a list of instructions. Additionally, they had difficulty carrying out procedures where lengthy lists were involved. In contrast, other studies have highlighted the positive aspects of dyslexia. Davies and Braun (1997) suggested that people with dyslexia can offer a range of skills, such as being intuitive and insightful, being highly aware of their environment and being able to think and perceive multi-dimensionally. The British Dyslexia Association (2003) noted that dyslexics often demonstrate an ability to think

and work differently, enabling them to produce innovative and creative solutions to problems.

Wiles (2001: 23) suggested that thinking holistically means that nurses with dyslexia can use a multi-dimensional approach to patient care and can visualise a patient as an integrated whole. Ikematsu et al. (2014) noted dyslexic nurses may be excellent in recognising subtle changes in patients' facial expressions or physical signs. Wiles (2001) also stated that dyslexic nurses use novel and creative problem solving measures that show an exceptional understanding of patients' individual needs. However, many often do not know or recognise the positives of dyslexia, including those who have dyslexia themselves (White 2007).

### **3.5.2 Classification of Dyslexia Versus Non-dyslexia**

In Chapter 2, in the discussion surrounding the defining of dyslexia, reference was made to the broadness of the presentation of dyslexia. Sir Jim Rose's definition notes the differences between dyslexics versus non-dyslexics and poor readers stating, 'Dyslexia is best thought of as a continuum, not a distinct category and there are no clear cut off points (Rose 2009: 33). This statement adds to the continuing debate about dyslexia and raises the question, does a nurse have to be dyslexic to experience these difficulties described in clinical practice? A number of the studies listed in Table 3.3 were comparative studies; that is, they used a non-dyslexic control group alongside the dyslexic student sample (Price & Gale 2006; Child & Langford 2011; Murphy 2011; Sanderson-Mann et al. 2012). This offers interesting insight when considering whether the non-dyslexic sample experienced the same or similar difficulties.

The study by Sanderson-Mann et al. (2012), which explored the impact of dyslexia on placement-based learning and compared dyslexic nursing students with non-dyslexic students, found that students, irrespective of whether they have dyslexia, find drug calculations and handovers of similar ease/difficulty. In addition, taking observations was regarded as one of the easiest tasks for both groups. However, the dyslexic students did state that reading and writing of observation charts was a problem, specifically inputting and interpreting pulse, temperature, blood pressure and respiration data on a ward observation chart. One significant finding from this study was that there was only a slight difference between a task rating difficulty for drug administration between the dyslexic and non-dyslexic student, with the dyslexic student finding this clinical task slightly more difficult. A five-point ordinal scale was used to test this. The results of this study raise an important consideration in this area of research, that experiencing difficulties in clinical practice might not be confined to a nursing student/nurse with dyslexia. A study by Price and Gale (2006), which explored the ability of nursing students to cope with clinical practice placements between a group of dyslexic and non-dyslexic students, notes similar difficulties between both groups, specifically in their organisational skills and understanding of medical and pharmacological language. Price and Gale (2006) emphasised the importance of respecting the individuality of a learner and the need to differentiate and vary the learning environment to meet the needs of different learning and cognitive skills.

A study by Murphy (2011) exploring student radiographers' perspectives of being dyslexic, sampled 14 dyslexic students and 23 non-dyslexic students. Some of the non-dyslexic sample reported difficulties with transposing numbers, poor listening skills and mixing up left and right, traits that could be characterised with being dyslexic. A

small-scale, qualitative study by Child and Langford (2011) also compared dyslexic and non-dyslexic nursing students. However, the results were inconsistent, which might have been reflective of the small sample size of six dyslexic nursing students and six non-dyslexic nursing students. The study only notes two similarities between the two groups: the clarity of written material and the value of the mentor in clinical placement. What these studies highlight is the presence of some dyslexic traits in some of the non-dyslexic student samples, which might suggest evidence of undiagnosed dyslexics amongst the nursing student population, but also other healthcare student populations including radiography, as highlighted by Murphy (2011). Alternatively, from a wider perspective, is there a broader existence of difficulties amongst the population that somewhat blurs the boundaries of dyslexics and non-dyslexics and rather presents more simply a population who present a varied range of difficulties in differing aspects of literacy and learning?

### **3.5.3 The Role of the Nurse Mentor and Nurse Preceptor**

The nurse mentor plays an integral role in supporting and assessing the nursing student during their clinical practice placement and the role very much determines a nursing student's competence in practice, as well as their fitness to practise. The nurse mentor is a registered nurse who is a clinical educator and professional member of the practice-based setting, who supports the nursing student during the clinical placement (Child & Langford 2011). The NMC (2006) stated the nursing curriculum places total responsibility upon the mentor to assess a student's fitness for practice. However, there are clear differences between the roles of mentor and preceptor. Mentorship is viewed as a broader, longer-term relationship aimed at guiding a novice towards an established place in the profession (Zwolski 1982). In contrast, preceptorship has a

narrower focus on individualised teaching, learning and support provision in the clinical setting post qualification (Neary 1997). Preceptorship is defined as a period to guide and support all newly qualified practitioners to make the transition from student to professional to develop their practice further (NHS Employers 2014), normally in their first six months of nurse registration.

In a study by Lawson (2010), mentors revealed they had problems knowing how to deal with a number of problems, including punctuality, aggression and personality clashes, but also problems dealing with learning difficulties such as dyslexia. White (2007) noted that the mentors in her study exploring the experiences of nursing students with dyslexia had received no instruction in supporting students with a disability, and all felt unprepared for their role.

In recent years, there has been a number of documents published providing guidance to mentors in supporting nursing students in practice. Guidance for mentors of nursing students and midwives – a toolkit (RCN 2007) – provides detailed guidelines on how to support nursing students in practice and includes a five-page chapter on students with disabilities, including a detailed section on dyslexia. In response to an increasing awareness of dyslexia in nursing, and in light of recent research on the topic as well as evidence of concerns surrounding inconsistent levels of support towards nursing students with dyslexia, the Royal College of Nursing (RCN) published *Dyslexia, dyspraxia and dyscalculia – a toolkit for nursing staff* (RCN 2010). The document aims to provide a practical guide for nurses about dyslexia, dyspraxia and dyscalculia, to raise awareness of these conditions as well as their overall impact and how best to provide support within a clinical area.

A further document was also published by the RCN, to be used in conjunction with *Dyslexia, dyspraxia and dyscalculia – a guide for managers and practitioners* (RCN 2010). This document is targeted at those who might work with, support or employ a nurse or nursing student with dyslexia, dyspraxia or dyscalculia. Both documents provide comprehensive and detailed information about these three conditions including specific difficulties individuals may experience, information about support, reasonable adjustments and disability legislation. However, these documents are not available in the wider public arena, only through the RCN website and publicised through associated RCN conferences and events. Therefore, it is argued not every nurse mentor might be aware of the existence of these documents, as not every nurse mentor is a member of the RCN with access to the advice and guidance they contain.

#### **3.5.4 Perceptions of Dyslexia by Mentors**

There has been a number of research studies that have explored the perceptions of dyslexia amongst mentors, though not as a specific focus, rather as part of larger studies surrounding dyslexia and nursing students or nurses (Illingworth 2005; Morris & Turnbull 2006, 2007a, 2007b; Price & Gale 2006; Crouch 2008; Ridley 2011; Sanderson-Mann et al. 2012). All of these studies highlight both negative and positive responses to dyslexia from nurse mentors in clinical practice. However, no study has explored preceptors' attitudes to dyslexia. One study from Canada (Johnston & Mohide 2009) entitled *Addressing diversity in clinical nursing education: Support for preceptors*, explored the issue of diversity amongst nursing preceptors; a key focus was upon general diversity issues including disability, spirituality, sexual orientation, age, culture and language. The study concluded that there was a need for specialised knowledge about diversity in clinical settings, and that preceptors needed to

understand their own beliefs and values about educationally related diversity. This relates to aspects of other studies exploring dyslexia and nursing from the perspective of a need for greater understanding as well as training surrounding the needs of the dyslexic nursing student or nurse in clinical practice (Price & Gale 2006; White 2007).

As highlighted in section 1.5 of the introduction, there is evidence of negative perceptions surrounding dyslexia and nurses, particularly regarding safety. There is evidence of a variety of negative responses to dyslexia from mentors in a number of studies. A student in Ridley's study commented: 'a few peers think it's just an excuse for people who are lazy' (Ridley 2011: 39). In the study by Illingworth (2005: 44) a student stated, 'She felt that there was no such thing as dyslexia and that people just jumped on the bandwagon and really they were just thick.' A study by Currell (2008) includes comments made by mentors to nursing students with dyslexia: 'She told me I could end up killing a baby' and 'Dyslexia is not real it is just an excuse.'

There was further discussion on the thoughts of some of the students in Morris and Turnbull's (2006) study on the actual basis of these negative views they had received:

Some indicated that the view of their dyslexia was influenced by society, noting that their colleagues never referred to the strengths of dyslexic people, but always to their weaknesses. (Morris & Turnbull 2006: 242).

In contrast, a number of studies have highlighted positive experiences from nursing students: Ridley (2011: 38) includes a number of dyslexic nursing students' comments with regard to their mentors: 'She [mentor] gave me time... was patient' and 'She [mentor] was lovely... kind and welcoming.'

A study by Morris and Turnbull (2007b: 103) that examined the impact of dyslexia on registered nurses also found a number of examples of positive support from colleagues and managers: 'My line manager is aware of my abilities, skills and knowledge and I know I can turn to her for support' and 'My colleagues are very understanding. They are always happy to proofread anything for me and point out any mistakes in important documents.'

In a more recent study by Crouch (2017), a number of the nursing and midwifery students commented on the positive support received by their mentors. One student midwife spoke of her mentor who had developed prompt cards to help her remember things. Additionally, one nursing student commented how the mentor had helped her grow as a student.

The actual assessment of nursing students by nurse mentors presents a number of dilemmas, particularly on the issue of subjectivity surrounding the assessment of nursing students in clinical practice: '...it would seem that subjectivity and misinterpretation are inevitable in assessment' (Bedford et al. 1993: 67). Additionally, Dolan (2003) highlighted that judgements by a mentor can be subjective and can vary from one mentor to another. With reference to dyslexia, the contrasting experiences of dyslexic nursing students and nurses highlighted here perhaps reflect this subjectivity in both the understanding and tolerance towards those with dyslexia.

These contrasting views of dyslexia by nurse mentors reveal opposing perceptions of dyslexia within the clinical setting. It is not possible to determine what might shape these perceptions, whether they are negative or positive. None of the highlighted studies explored in depth the origins or reasons for the nurse mentor's perceptions of

dyslexia. This would require a more in-depth interview process to explore the mentors own personal thoughts on possible reasons for their approaches and attitudes towards nursing students with dyslexia. It might be proposed that on examination of the negative perceptions of dyslexia in these studies, a degree of stigma surrounding dyslexia amongst a number of nurse mentors exists. This stigma links closely to the fear of disclosure by nursing students and nurses with dyslexia highlighted in the following section of this chapter.

### **3.5.5 The Disclosure of Dyslexia**

The concerns surrounding dyslexia voiced by some mentors and the associated stigma could also potentially affect those who have dyslexia themselves. This might have a resultant impact of many nursing students and nurses' unwillingness to disclose their dyslexia to others, specifically mentors and nursing colleagues in clinical practice. A number of studies have explored this issue. Illingworth (2005); Sanderson-Mann and McCandless (2005); Morris and Turnbull (2006, 2007a, 2007b); White (2007); Ridley (2011); Sanderson-Mann et al. (2012); and Crouch (2017) all reported that a number of nursing students/nurses with dyslexia were unwilling to disclose for fear of negative reactions from mentors and colleagues. However, in contrast, other participants in Ridley's (2011) study were willing to disclose their dyslexia in practice. For the most part, the rationale for this self-disclosure was responsibility in the interests of patient safety. Other reasons for self-disclosure included access to support from mentors and colleagues. Morris and Turnbull (2007b) noted a number of students in their study identified the importance of disclosure of dyslexia, as support would not otherwise be forthcoming.

Those who chose not to disclose varied greatly between each study. The study by Morris and Turnbull (2007a) explored the disclosure of dyslexia in clinical practice by UK nursing students; six out of 12 chose not to disclose. In the study by Ridley (2011), which explored the experiences of nursing students with dyslexia, all seven participants disclosed but stated that disclosure in clinical practice was more challenging in comparison to the university setting. Four of 116 nurses chose not to disclose in the study by Morris and Turnbull (2007b) into the career progression of registered nurses with dyslexia.

The study by Morris and Turnbull (2006) investigated the clinical experiences of nursing students with dyslexia; 12 of the 18 students had some degree of discomfort in disclosing their dyslexia to clinical staff. The study by Sanderson-Mann et al. (2012), which explored the impact of dyslexia on placement-based learning, did not specify exact figures of non-disclosure amongst participants, but noted some students told others they were dyslexic only if they judged it appropriate or necessary, or if they thought that being dyslexic was going to be a problem. The study by Illingworth (2005), which explored the effects of dyslexia on the work of nurses and healthcare assistants, revealed six out of the 12 chose not to disclose, giving reasons of lack of understanding by mentors about dyslexia and fear of misjudgement.

The study by White (2007) looking into the support of nursing students with dyslexia in clinical practice, again did not specify exact figures of non-disclosure but found that the students made conscientious decisions about disclosure, influenced by factors relating to their previous experience of disclosure, which was often negative. A study by Devereux et al. (2012) exploring why healthcare students fail to disclose health

problems showed some students are at best ill-informed about how personal health and disability may affect practitioners' ability to deliver safe and effective practice. A published MSc thesis by Currell (2008), which explored the academic experiences of nursing students with dyslexia, notes that one nursing student did not wish to disclose her dyslexia as she stated 'I don't tell people that I'm dyslexic... I just don't think they have a concept of it.' A more recent study by Major (2017) investigating the personal and professional experiences of nurses with dyslexia describes how many of the nurses in her study expressed fear and concern about disclosing dyslexia for fear of others reactions, as well as the presence of a stigma. Additionally, a further recent study of nursing and midwifery students by Crouch (2017) noted that many of the students did not wish to disclose for fear of being judged by others as incapable, stupid or weak.

To disclose any disability is complex and may be directly related to past experiences or the perceptions and expectations of themselves and others (Osmond 1993; Blankfield 2001). Evans (2013), who explored the identity constructions of dyslexia amongst nursing students, highlights the complexity of disclosure in a study; this study revealed that how the students placed their dyslexic identity influenced their level of disclosure. Evans (2013) devised three broad categories of how students positioned their dyslexic identity: embracer; passive engager or resister, which directly influenced their disclosure positions outlined as follows:

- I have dyslexia (embracer)
- I experience the following difficulties (passive engager)
- I fail either to mention that I have dyslexia or that I have difficulties (resister)

(Evans 2013: 368)

Evans (2013) argued that, in light of these findings disclosure was less opaque; it no longer reflected a simple 'yes' or 'no' decision, but was more complex and interacted with dyslexic identities, which were in turn mediated by previous or current influences (Stanley et al. 2011). Howlin et al. (2014) noted that disclosure of a disability by nursing students is challenging and difficult for the majority of the students. It is also influenced by the environment and the personal characteristics of the student.

A number of the core studies previously discussed have highlighted disclosure of dyslexia, noting the participant's reasons for not disclosing. A common theme amongst these reasons was fear of a negative reaction from others. In contrast, there were participants in some of these studies who would disclose for reasons of an awareness of patient safety, access to mentor support, and help emphasising the importance and justification for disclosure in this context (Morris & Turnbull 2006, 2007a; White 2007; Ridley 2011). However, others would disclose with caution or only on a 'need to know' basis. The evidence from these dyslexic nursing students and nurses could indicate the existence of stigma surrounding dyslexia, in light of the many who voiced their reluctance to disclose their dyslexia. In pinpointing reasons for this stigma, thought turns to the perception of literacy in society. Sanderson-Mann and McCandless (2005) stated that literacy is defined as a socially constructed phenomenon. Cook-Gumpertz (1986: 1) noted that 'Literacy is not just the simple ability to read and write: but by possessing and performing these skills we exercise socially approved and approvable talents.'

Therefore, is it purely society's heightened view of literacy and the emphasis placed upon it for success and educational achievement that creates stigma for those who have dyslexia? Personal negative experiences of those who have dyslexia also contribute to the stigma those individuals believe exist. It can be argued the greater the negative experience they have, the greater they believe a stigma exists. This contributes towards the perception of self with regard to dyslexia, which will be discussed in detail in section 3.7.

With reference to disclosure of dyslexia, the perception of self is significant. The complex differences amongst nursing students/nurses who disclose or do not disclose their dyslexia and those who disclose their dyslexia only in certain circumstances has already been surmised. Bruner (1996) suggested that sense of self is more or less directly proportional to the individual's concept of his or her own powers. This was further interpreted by Reed (2001: 21), who stated, 'to know one's self is to appreciate one's capacities in different circumstances.' Therefore, when an individual chooses to disclose or not to disclose their dyslexia to others is dependent upon this individual's self-appraisal as well as the differing circumstances they find themselves in. The likelihood of disclosing a dyslexic identity in clinical practice increases where an approachable and accepting atmosphere exists (Halligan & Howlin 2011).

Disclosure of dyslexia is a complex multi-level process that has significant impact upon the dyslexic nursing student/nurse in clinical practice (Morris & Turnbull 2007b; Evans 2013). There are clear differences in reasons to disclose or not to disclose amongst affected individuals. Evidence of non-disclosure or caution when disclosing dyslexia, reflects the presence of a stigma surrounding dyslexia. One possible reason for this

stigma might be the perception of literacy in society and the connection between literacy and dyslexia with the inherent difficulties that many dyslexics face with literacy skills previously highlighted. The disclosure of dyslexia is further influenced by the self-perception of the individual with dyslexia, specifically the construction of identity, which will be detailed further in section 3.7. Additionally, disclosure is an important part of the support process (Stampoltzis and Polychronopoulou 2009); therefore, in this context, the role of the mentor is significant in enabling disclosure of dyslexia. This is an under-researched area of dyslexia research, but is an important consideration in the context of this study.

### **3.6 The Nursing and Midwifery Council – Fitness to Practise and Safety in Practice**

The Nursing and Midwifery Council (NMC) is the professional regulator for the nursing profession in the UK and maintains a register of all nurses and midwives eligible to practise in the UK. One of its key objectives is to ensure protection for the public through the registration and regulation of nurses and midwives. This section opens with a review of the literature surrounding safety and the nurse with dyslexia and outlines the position of the NMC in relation to fitness to practise in the context of dyslexia.

#### **3.6.1 Safety and the Nurse with Dyslexia**

It is clearly apparent from the evidence presented in Tables 3.4, 3.5 and 3.6 that nursing students/nurses with dyslexia experience a variety of difficulties with particular clinical tasks. However, from these difficulties, concerns are raised over safety, specifically whether a nurse or nursing student with dyslexia is safe to practise in light of such clinical difficulties. A number of these concerns are for the most part anecdotal.

However, there exist concerns about the ability of dyslexic nurses to read drug names (Duffin 2001; Watkinson 2002). Drug administration is a key nursing clinical task where the occurrence of any error during this task could result in harm to a patient or in the worst case, the death of a patient. Watkinson (2002: 30) in a letter to the Nursing Standard wrote:

I have been taught that giving medications involves much reading: the right patient, the right medication, the right dose, the right time, the right method. Since a nurse with dyslexia would be unable to follow these steps, I cannot understand how they would be able to give out medications safely.

It is noted that this view is a single opinion, rather than credible evidence through research, but it demonstrates one societal view of dyslexia. Additionally, it was reported by Paul Lewis, of the United Kingdom Central Council for Nursing (now the Nursing and Midwifery Council) that he knew of a nurse with dyslexia who used the colour of tablets and the size of bottles as a basis for matching medications to patients (Millward et al. 2005). Again, this report was anecdotal and therefore not reliable evidence. However, it is these anecdotal reports that raise fear and concern amongst members of the profession and the public; they might be described as discourses. Discourse is defined by the New Oxford Dictionary (2001: 527) as 'written or spoken communication or debate'. This written or spoken communication generated about dyslexia creates a dyslexia discourse. The language about dyslexia in nursing can sometimes be quite negative, as previously highlighted. However, this language and talk can directly influence how dyslexia might be perceived in society, from what people hear or read and specifically how it is socially constructed. In a letter to the Nursing Standard, Blankfield (2002: 31) stated that 'the biggest problem for a nurse with dyslexia is the attitude of non-dyslexic employers, placement tutors and colleagues

who, according to students I know, tend to react with horror or sympathy when dyslexia is disclosed'.

However, despite the presence of this dyslexia discourse, there currently remains no empirical evidence to prove or disprove that a nurse with dyslexia is not safe to practise (Wright 2000; Morris & Turnbull 2006). A Japanese study on nursing students with special educational needs including dyslexia (Ikematsu 2014) noted that some or all of their difficulties, such as issues with receptive and expressive oral language, reading and computation, could be obstacles for students to study nursing. In contrast, other studies challenge the issue of dyslexic nurses and safe practice. Illingworth (2005) noted in her study, that one participant never had a problem with drug names, and that drug names are not common and are initially alien to everyone. Ridley (2011) noted the students in her study were attuned to areas of personal difficulty and sought appropriate supervision to safeguard themselves and those in their care. With specific reference to drug administration, a number of studies have highlighted that nursing students with dyslexia demonstrate hypervigilance in such clinical situations (Wright 2000; Morris & Turnbull 2006, 2007b; White 2007; Ridley 2011). Sheehan and Nganasurian (1994) in their study stated dyslexia can make nurses extra vigilant and drug errors can be made by anyone, by either dyslexics or non-dyslexics.

It is argued that dyslexic nurses are likely to have well established coping strategies or adaptations and therefore not be any risk to patient safety (Aiken & Dale 2007). Corley and Taymans (2002) highlighted a dyslexic nurse's heightened self-awareness or 'metacognition', such as understanding one's learning difficulties including specific information processing deficits. Morris (2006) argued that an awareness of a dyslexic

nurse's own deficit or difficulty would make an individual aware of their own limitations and thus would promote patient safety. Millward et al. (2005: 343) highlighted the variability of dyslexia and the variety of complex coping strategies that many dyslexics would possess. White (2007) described how a nursing student would manage whilst administering drugs by asking a registered nurse if she had any doubts about a name of a drug because of her dyslexia:

Morris and Turnbull (2007b) explored the career progression of registered nurses with dyslexia and found that many respondents (38.8% n = 45) reported their need to check and re-check and often confirm the accuracy of their practice with colleagues. Patient safety was cited as the primary rationale for this behaviour within this group (82.2% n = 37). Major (2017) also reported dyslexic nurses in her study also demonstrated hypervigilance in drug administration. It is argued that this observation of double checking and emphasis upon ensuring accuracy by nursing students/nurses with dyslexia when administering drugs might be second nature to a dyslexic nurse because of their recognition of their dyslexia as well as their concern for patient safety. In contrast, it is argued that non-dyslexic nurses may be prone to complacency (Cobley & Parry 1997) and thus might not practise the same hypervigilance demonstrated by their dyslexic counterparts. A study by Murphy (2011), which explored dyslexia amongst radiography students, noted evidence of self-awareness amongst dyslexic students who would check and recheck x-ray request cards as well as recheck patient positioning prior to taking an x-ray.

Despite this evidence of hypervigilance and self-awareness by dyslexic students surrounding clinical procedures, a study by Evans (2014: 44), which explored nurse

lecturers' constructions of students' dyslexic identities, noted a response from one lecturer's reaction to nursing students with dyslexia: 'If they can't tell the difference between duphalac and digoxin, you've got patient safety issues.'

This highlights further concerns around patient safety specifically from a nurse lecturer within a nurse education environment, but also perhaps demonstrates a lack of either understanding or knowledge of the evidence of hypervigilance or self-awareness shown by dyslexic nursing students surrounding drug administration. What is particularly notable about this study is that it is the only study I identified to have explored the perceptions of nurse lecturers about dyslexia.

In 2005, the Council for Healthcare Regulatory Excellence (CHRE) considered whether people who have dyslexia should be accepted onto nursing courses as reported by the Nursing Standard (2005). At the time, the then NMC deputy president Mary Hanratty said 'universities support students with dyslexia, but students do not get that support once they are on the register. The safety of patients is paramount' (Nursing Standard News 2005: 5). Despite this, the final report *Trust, assurance and safety – The regulation of health professionals in the 21st century* (NMC 2007) made no mention of either dyslexia or disability amongst healthcare professions. It might be argued whether the dyslexia discourse surrounding dyslexic nurses and safety highlighted earlier might have influenced this response. However, it is significant that the NMC might consider such a move and this raises further discussion surrounding the NMC's position on dyslexia and nursing. This will be detailed further in section 3.6.2.

The issue of safety and dyslexia in nursing is clearly a contentious subject that raises a number of arguments and questions. One of the key questions raised is whether

nurses with dyslexia are safe in clinical practice. The statement highlighted earlier that there is no empirical evidence to prove or disprove whether a nurse with dyslexia is not safe to practise warrants further investigation. An exploration of the existence of any such empirical evidence was undertaken by Aiken and Dale (2007), who investigated reported cases of patient harm by both the General Medical Council and the Health Professions Council, but found no reported cases of patient harm or concerns about fitness to practise due to errors made by dyslexic staff. However, Aitken and Dale (2007) noted the National Patient Safety Agency in 2006 had reported three such cases were reported to them in the previous four years. In 2008, there were a total of 863,691 patient safety incidents reported to the National Reporting and Learning Service (NRLS); of these, 80,150 were related to medication (NPSA 2009). This figure is significant when compared to the NPSA (2006) findings that out of all cases reported to them over the previous four years, only three cases involved that of dyslexia and nurses. The three cases are outlined as follows:

- **Case 1** involved a health care assistant (HCA) who took a reading from a patient for a blood clotting time, but the reading she recorded did not match that recorded in the patient document and as a result medication was not prescribed. However, the HCA did report she was under a great deal of stress due to home circumstances, which heightened her dyslexia problems.
- **Case 2** was a student nurse with borderline dyslexia who misdialled a digit in a fax number when sending a patient's details and treatment plan to an assessment unit. The documents went to a private home address and the resident then informed the district nurse.

- **Case 3** was at an outpatient clinic where a staff nurse from another clinic registered a patient, saw an x-ray form and sent the patient to the x-ray department. However, the staff came back with the patient querying why she had been sent, as the form was actually an x-ray report containing sensitive information about a tumour. The staff nurse was suspected of having dyslexia but no formal diagnosis had been confirmed at that stage.

In all these cases, it should be noted no actual harm came to the patients involved. Further analysis of these cases reveals that in case one, the nurse reported suffering a great deal of stress at home. Stress might be considered a key contributory factor for any person who has made an error during their working day with or without dyslexia. However, it is argued that the performance of dyslexics in specific cases can be affected by stress (Kolanko 2003). In case two the student nurse was described as having borderline dyslexia and the misdialling of one digit on a phone is an error that, it could be argued, could be made by anyone. In case three, no formal diagnosis of dyslexia had yet been confirmed and working within a busy x-ray department, picking up an incorrect form could again be an error anyone could make. Therefore, it might be concluded from the details of these three cases regarding the contributory factors, lack of clarity and potential doubt over whether some of the nurses had dyslexia, was dyslexia actually the true cause of these errors or was it just simple human error? Additionally, it is questioned if the nurses in these three cases did not have dyslexia, would these cases have been reported? Was dyslexia the actual impetus for raising a concern or could societal views of dyslexia have also influenced the reporting of these cases?

It is argued that nurses, like all humans, are prone to error and uncertainty in their actions and decision making (Thompson & Dowding 2004). Further exploration of the NPSA (2015) website revealed UK patient safety incident figures from January to December 2014 as 1,722,640, with no indication of dyslexia as a contributory cause in any of these. However, the NPSA (2010) produced a classification framework of nine contributory factors that might contribute to patient safety incidents: within the staff factor, disability is highlighted, giving poor eyesight and dyslexia as examples of disabilities. Placing it alongside poor eyesight, perhaps positions dyslexia as a sub-type of visual deficit, which impacts upon reading and writing. However, Irlen syndrome is a perceptual processing disorder; it is not an optical problem, rather an issue with the brain's ability to process visual information (Irlen 2017). This is highly significant in that of all the many known disabilities, dyslexia is highlighted as an example in a document listing contributory factors surrounding patient safety incidents. This raises a discursive question; why was dyslexia specifically cited as an example? It could be argued the commonality of dyslexia, with figures of it affecting one in ten of the UK population, might justify its inclusion. Disabilities are present in many forms and types, there are a wide range of disabilities including physical, mental health and learning disabilities; is dyslexia perceived as such a high risk in patient safety incidents to be included in such a document? Does the inclusion of dyslexia in this context reflect society's overall discursive view of dyslexia?

In contrast to cases one to three reported by the NPSA, and the issue of safety in clinical practice and the dyslexic nurse, a significant case involving a registered nurse with dyslexia was brought before a NMC professional hearing in 2008. It raises a

number of concerns over the safety and fitness for practice of a nurse with dyslexia in clinical practice. The details of the case are summarised below:

A dyslexic nurse who worked in a brain surgery ward but could not read medicine bottles labels or remember patients' names has been suspended today (Fri). Claire Janes, 32, was so incompetent she was not fit to work in any part of the Queen's Medical Centre in Nottingham, the Nursing and Midwifery Council heard. (Burton Mail 2008)

Additionally, the story was reported in the press at the time and the nature of the headlines 'Blunder nurse was out of her depth' (Burton Mail 2008), demonstrates the use of negative language in relation to dyslexia, specifically the use of the word 'blunder'. As has been highlighted previously, such language might be another example of dyslexia discourse where the fear surrounding a nurse is heightened through a media report and in this context adds further concerns surrounding dyslexic nurses and unsafe practice.

A similar case was reported in the Scotsman (2003): 'Demoted dyslexic nurse faces losing her job', which detailed an incident of confusion over the name of two drugs. Both nurses in these cases received a 12-month suspension from the nursing register by the NMC Conduct and Competence Committee. However, my initial thoughts surrounding these two cases were to consider a number of key questions. What occurred whilst these two individuals were nursing students? Were their difficulties highlighted by their mentors? Was any action taken to deal with these difficulties? Why were they passed as competent as students? When were they deemed incompetent by the NMC as registered nurses? In what precise context were they identified as incompetent? Were there other factors occurring in either nurses' life at the time, which were not detailed or made public? These particular cases and the questions and

thoughts that arose from them led me to consider how a nursing student with dyslexia manages the transition from nursing student to registered nurse. Additionally, the NMC plays a significant professional role, firstly by setting the competencies and standards a registered nurse must meet and providing advisory guidance surrounding a nurse/nursing student with a disability in both the educational and clinical setting. The following section explores the NMC's position in relation to fitness to practise in the context of dyslexia.

### **3.6.2 The Nursing and Midwifery Council and Fitness to Practise**

'Fitness to practise' is defined as a person's ability to practise their profession in a way that reliably meets appropriate standards, meaning that the person has the skills, knowledge, attitudes, character and health to perform necessary functions safely and effectively (Health Professions Council (HPC) 2009, 2010). The NMC (2015b) clearly states that a nurse or midwife must be fit for practice at the point of registration. It also adds that a nurse being fit to practise requires a nurse or midwife to possess the skills, knowledge, good health and good character to do their job safely and effectively. The key function of the NMC is stated as follows:

Our core regulatory functions are maintaining a register of those eligible to practise as nurses and midwives in the UK, setting standards to join and remain on the register, and acting when there are concerns about the conduct or practice of a nurse or midwife. (NMC 2015b: 2)

However, how might these regulatory functions be applied to the cases of the two dyslexic registered nurses suspended from the nursing register because their practice was deemed unsafe, as detailed in section 3.6.1? Clearly patient safety in a clinical setting must always be paramount and where patient safety is compromised, this must be fully addressed and investigated. If any healthcare professional or group of

healthcare professionals are found to be responsible, action must be taken through professional regulatory bodies such as the NMC.

As previously highlighted in section 3.6.1, concerns surrounding safety and the dyslexic nurse have been raised in the past, but the majority of these concerns were anecdotal in nature. Additionally, evidence of hypervigilance by nurses with dyslexia particularly in their drug administration, as highlighted in a number of studies (Sheehan & Nganasurian 1994; White 2007; Morris & Turnbull 2006; Ridley 2011), appear to address some of these concerns to a degree. It has been claimed by Wright (2000) and Morris and Turnbull (2007a) that there is no empirical evidence to prove or disprove a nurse with dyslexia is not safe to practise. However, the two cases of dyslexic nurses suspended from practice by the NMC, clearly challenges this claim. Therefore, the question remains; when does the clinical practice of a nursing student/nurse with dyslexia become perceived as a threat to safety? This could, in certain instances be open to professional interpretation. Morris and Turnbull (2006) noted that in nursing, the exact explanation of fitness for practice has been devolved to local level and additionally there is as yet no definitive statement on support for dyslexic nurses; however, there are two NMC documents that guide the maintenance of standards and conduct within the nursing profession:

- NMC – *The Code – Standards for practice and behaviour for registered nurses and midwives* (2015c)
- NMC – *Standards for competence for registered nurses* (2010b)

These two documents outline standards for practice, competence and professional behaviour within nursing. If a nurse or midwife is seen not to meet one or more of these

standards and/or competencies in clinical practice, due to either incompetence or misconduct, they may be called before a fitness to practise panel to answer to such a claim. This may result in a formal warning, a period of supervised practice, suspension or a striking off order. However, it has been argued that regulatory fitness requirements are open to misinterpretation.

A year-long investigation by the Disability Rights Commission was published in 2007 (DRC 2007b) into the impact of fitness standards on disabled people studying, qualifying, registering and working in three public sector professions, teaching, social work and nursing. This investigation recognised that the potential for systemic discrimination against disabled people lies in the existence and nature of regulatory fitness requirements, as well as how these might be interpreted and implemented in practice. Scullion (2010) argued that disability is still viewed as a medical phenomenon synonymous with illness, deviation or dependence within the health professions rather than an equality issue. Wright and Eathorne (2003) argued that disabled people may be seen as unfit to enter the healthcare professions. The NMC document *Standards of Proficiency for Pre-registration Nursing Education's* (2004) statement on disability appeared to reflect this view that disability was still viewed as a medical phenomenon, requiring a formal assessment from a GP of their condition and specific needs and thus voicing some caution as to the entry of students with disabilities into nursing:

Students who declare on application that they have a disability should submit a formal assessment of their condition and specific needs, from a GP or other medical or recognised authority and to the relevant occupational health department. (NMC 2004: 10)

However, this 2004 document was superseded by the *Standards for Pre-registration Nursing Education* (NMC 2010a). This appeared to take a more equitable view of

disability in the profession reflected in the following statement, with no reference to assessments by GPs: 'Programme providers must treat all students fairly, and ensure equality of opportunity regardless of race, gender, disability, age, religion or sexual orientation' (NMC 2010a: 52).

This was a response to the Equality Act (2010), which placed disability alongside race, gender, age and sexual orientation and collectively grouped them as protected characteristics, with an emphasis upon equality, diversity and fairness. A further NMC document *Good health and good character – a guide for educational institutions* (NMC 2010c) was amended from its original 2008 publication in direct response to the Equality Act (2010) stating they had made 'some minor amendments to the content to ensure we are meeting our duties to the Equality Act'. Therefore, there appeared to be a shift in approach to disability by the NMC in a direct response to the Equality Act (2010). Martin (2012) stated that the requirements of the Equality Act (2010) make it incumbent upon staff working for public bodies, including universities, to challenge oppression of marginalised groups, including disabled people. It can be suggested that this is what the NMC is attempting to do in publishing these amendments to reflect this new equality legislation.

### **3.6.3 Reasonable Adjustment and Competence**

In Chapter 2, reasonable adjustments and competence standards were outlined in relation to a nurse or nursing student with a disability. This section further explores reasonable adjustments and competence, making reference to a number of past and current NMC documents as well as current disability legislation.

The NMC document *Good health and good character – a guide for educational institutions* (NMC 2010c: 8) recommends that the responsibility for any decision surrounding reasonable adjustments for students with disabilities should be with the nursing programme providers within HE institutions: 'We recommend that programme providers and employers consider what reasonable adjustments a student or registered nurse or midwife needs as early possible...'

One key observation of this statement is that the NMC is passing on the responsibility directly to programme providers to decide what reasonable adjustment is needed, rather than providing specific guidance on reasonable adjustments themselves. A weakness of this statement is such practice could result in a lack of uniformity amongst employers and programme providers around the country in how they enforce reasonable adjustments. Additionally, the Disability Rights Commission (2007b) investigation into disabled people and professional regulation within nursing, teaching and social work made a key recommendation that called for explicit national guidance on the assessment of individuals with a disability, rather than relying on local policies, which could lead to discriminatory practices. However, it is worthy to note that this investigation by the DRC (2007b) was prior to the Equality Act (2010). The *Good health and good character* (NMC 2010c) document directs the reader to the Equality Act (2010: 10) to determine what might be reasonable:

...where a provision, criterion or practice of A's puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage.

One criticism of this explanation of reasonable adjustment is its description of a substantial disadvantage, which could be open to professional interpretation by either

the employer or disabled employee. Furthermore, the term 'reasonable' is difficult to define and might be determined solely by means of cost, resources and practicality, which may vary greatly from one HEI or NHS trust to another. A later NMC document, *Character and health decision-making guidance* (2015: 7), which superseded the previous 2010 document, also makes reference to reasonable adjustments:

...NMC Order states that applicants to the register must satisfy the Registrar that they are of sufficiently good health to be capable of safe and effective practice. Good health" means that the applicant is capable of safe and effective practice either with or without reasonable adjustments. It does not mean the absence of a health condition or disability.

This places the emphasis upon safe and effective practice with or without the reasonable adjustment, but adding that this does not mean the absence of a health condition or disability. In the context of a registered nurse in practice, such safety is clearly paramount; therefore, reasonable adjustments are important for those who have a disability or 'special' needs.

Reasonable adjustments within an academic environment are quite straightforward but determining whether recommended adjustments are 'reasonable' in practice settings can provide complex challenges (Tee et al. 2010). Duffy (2003) also argued that the provision of reasonable adjustments can be challenging due to the potential diversity of practice experiences and the limited time that mentors have to support learning. In relation to reasonable adjustments in practice and dyslexia, a study by Illingworth (2005), which explored the experiences of nurses and healthcare assistants with dyslexia in clinical practice, identified dyslexia-friendly practices within their hospitals. These included providing computers, allowing access to degree courses and other courses to develop potential, giving extra study leave for these, getting help and

support from colleagues and managers, clear structures such as signs and simple notices with large words and pictures, and having a repetitive work pattern. These adjustments might be described as minor, requiring little cost for implementation. However in contrast, the Equality Challenge Unit (2015) described problems where nursing mentors were not always comfortable with the reasonable adjustments proposed for a particular student. Reasons for these problems could be about the practicality of the adjustment in the placement environment or about whether the adjustment compromised the assessment of the student's practice. The Equality Challenge Unit (2017), in light of these findings, recommended a need for a process for reaching a common understanding between HEI support and placement practice.

The question of when the clinical practice of a nursing student/nurse with dyslexia is perceived as a safety risk is a question interspersed with many complexities, including professional interpretations, personal perceptions, professional standards and guidelines, discrimination, and fitness for practice regulations. Price and Gale (2006) claimed the overriding consideration in nurse education in clinical practice has to be danger versus safety. This is true when you consider the potential implications of unsafe practice upon patients, but there must be much unpicking of the finer details and complex elements surrounding this issue to reach a reliable conclusion in any given case. As previously stated, patient safety is paramount, but coupled with this is a need for a greater understanding and acceptance of nursing students/nurses with dyslexia and other disabilities in clinical practice. Consideration must be given to elements of support, supervision, and professional standards and competence in such circumstances. With direct reference to the issue of competence, the Equality Act (2010: 191) makes a direct reference to competence stating:

You are under a duty to make reasonable adjustments to your assessment methods, **but not** to the application of the particular academic, medical or other standard, you are applying to determine whether or not the students have a particular level of competence or ability. Such a standard is known as a competence standard.

This statement makes a clear indication that the actual achievement of competencies, professional standards or abilities is outside the duty of reasonable adjustments, thus making it legally correct for an employer to deem a disabled employee as either competent or not competent, or to lack sufficient ability to perform a specific task. However, the statement importantly adds that in relation to the methods of assessment used to assess the competency of a disabled student, organisations have a duty to make a reasonable adjustment to the methods of assessment of that particular competency. The NMC remain reticent about a nursing student's need to demonstrate their requirements that a qualified nurse (with or without a disability) is capable of independent practice, and the HEI must be satisfied of this at point of registration to meet the standards of professional nursing practice.

### **3.7 Perception of Self and Dyslexia**

The concept of self in the person with dyslexia is an important consideration in this study as one of its aims is to investigate influences that might shape the professional and educational experiences of dyslexic nursing students. These influences might also consider the participant's own feelings and thoughts about being a person with dyslexia. Therefore, this section examines the literature surrounding perception of self and identity in dyslexia, as well as the impact of self-esteem on a person with dyslexia.

### **3.7.1 Perception of Self and Identity in Dyslexia**

The negative perceptions of dyslexia by others were highlighted previously in section 3.6.1, detailing safety and the nurse with dyslexia. However, the self-perception of dyslexia by those who have dyslexia is an area of study where only limited research exists. Burden (2005) stated that self-perception is also referred to as the construction of the self-concept. However, in contrast, self-perception and self-concept have somewhat different meanings; Rogers (1951: 138) defined self-concept as:

Composed of such elements as the perceptions of one's characteristics and abilities: the precepts and concepts of the self in relation to others and to the environments: the value qualities which are perceived as associated with experiences and objects and the goals and ideas which are perceived as positive and negative valence.

Marsh and Salveson (1985) broadly defined self-concept as a person's self-perception of him or herself and such perceptions are formed through experience with and interpretations of one's environment. In contrast, Bem (1972) described self-perception as individuals coming to 'know' their own attitudes, emotions, and other internal states, partially by inferring them from observations of their own overt behaviour and/or the circumstances in which this behaviour occurs.

Therefore, with reference to these contrasting definitions, the previous evidence highlighted in section 3.5.4 of negative perceptions and comments by mentors and others about nurses with dyslexia and the subsequent impact of such perceptions bears some consideration regarding self-perception and self-concept. Through self-concept, when nurses with dyslexia experience negative perceptions from others towards dyslexia, their own interpretation of these experiences could potentially influence the impact upon their own perception of themselves. Fitzgibbon and

O'Connor (2002) described how a direct negative effect of dyslexia, such as experiencing difficulties in the workplace, can result in being judged unfairly. Additionally, through self-perception, these same negative experiences could heighten their awareness of their own attitudes and emotions of themselves as a dyslexic within the workplace. Howlin et al. (2014) highlighted how the disclosure of a disability can be influenced by a student's personal characteristics.

Identity, from a sociological perspective, 'refers simply to a social category, a set of persons marked by a label and distinguished by rules deciding membership and (alleged) characteristic features or attributes' (Fearon 1999). Caldas-Coulthard and Fernandes-Alves (2008) argued that identities are constructed discursively. Taylor and Littleton (2006) claimed that identities have the potential to be altered in talk and interaction. This can be related to anecdotal talk including the concerns raised about the ability of dyslexic nurses to read drug names (Duffin 2001; Watkinson 2002), previously highlighted in section 3.6.1. Additionally, as found in section 3.5.4, evidence of reports of nurse mentors in clinical practice who have voiced negative comments about dyslexic nursing students (Price & Gale 2006; Illingworth 2007; Morris & Turnbull 2007a; Crouch 2008).

This talk can contribute to the construction of dyslexia, specifically within nursing, which can influence the self-identity of the dyslexic nursing student/nurse. However, in contrast, one student with dyslexia described their dyslexia as being part of them: 'I would not want to be cured; it is part of the way I think and learn' (Cobley & Parry 1997: 39). This student's view of their disability not as a handicapping condition but as an essential part of their identity is described as 'reframing' (Gerber et al. 1996). Such

reframing can affect the learning experience influencing the degree to which students accept and understand their disability (Sanderson-Mann & McCandless 2005). Ijiri and Kudzma (2000) noted that the dyslexic nursing students in their study found the difficulties they faced and often struggled with led them to profound tenacity and appreciation for their uniqueness as learners.

A study by Evans (2013), which explored identity constructions of dyslexia amongst 12 nursing students at two nurse education sites in the Irish Republic, revealed the different constructions of identities amongst a group of dyslexic nursing students. This is a unique piece of research as there is no evidence of any previous studies exploring identity constructions of nurses with dyslexia. What was particularly revealing about this study was the framing of the dyslexia identity by the nursing students, rejecting the traditional medical and disability-impaired language and embracing a more contemporary construction, such as being more creative and 'having specific skills' (Pollak 2005; Gwernan-Jones 2010). Evans (2013) also reported in his study that the students appeared to be asserting their right to be the same as other students in their cohort. This was apparent through their unwillingness to disclose their dyslexia to their mentors, with one student stating that she did not wish people to 'look at you different'. Evans' (2013) study found that a dyslexic identity is contextual, defined by the students' previous and current situation in nurse education, specifically previous experiences in practice placements as well their current practice placement.

Burden (2005) argued that the dyslexic self-concept is often influenced by the value society places upon literacy. Self-stigma, is defined by Almeida as 'an internal process whereby people judge themselves based on messages received from societal norms'

(2012: 90). Beliefs about how others see us are particularly characteristic of a number of dyslexic nursing students/nurses' perceptions whilst in clinical practice. This was apparent in studies by Morris and Turnbull (2006, 2007a), Price and Gale (2006), White (2007), Child and Langford (2011) and Ridley (2011). What was particularly apparent in these studies were not just the negative and often discriminatory attitudes of some mentors, but also the cautionary actions of dyslexic nursing students/nurses of not disclosing their dyslexia for fear of negative attitudes towards dyslexia. Major (2017) noted in her study exploring the personal and professional experiences of dyslexia amongst nurses, that disclosure was a threatening process, which could have implications for their professional and academic self-concepts. Under such circumstances, it can be determined that the impact of such experiences can very much shape the self-concept or self-identity of a dyslexic nursing student or nurse and also potentially influence self-esteem.

There have been a number of research studies that have explored the links between dyslexia and self-esteem (Riddick et al.1999; Baker & Ireland 2007; Burden 2008). All these studies concluded there was a clear link between dyslexia and low self-esteem, but emphasised this could not be generalised to every individual with dyslexia. The subject of self-esteem and dyslexia will be discussed in further detail in section 3.7.2.

The perception of self for all people is a complex and multifaceted concept, which potentially can be influenced by the talk and attitudes of others as well as the culture of an environment or workplace. However, how dyslexics perceive themselves remains an under-researched area as well as an important consideration in dyslexia research. There are large amounts of research surrounding the presentation of dyslexia, as well

as the many different theories and causes of dyslexia. With direct reference to nursing students and nurses with dyslexia, taking account of the impact of negative attitudes of others and the societal value of literacy, it can be surmised that the negative impact on both identity and self-esteem upon these dyslexic individuals within clinical practice might be significant.

### **3.7.2 Self-Esteem and Dyslexia**

Self-esteem has a link to self-concept in terms of their relationship to the 'self' and the person's perception of the 'self'. However, both terms have different meanings, despite often being used interchangeably in many research studies surrounding self-concept and self-esteem (Humphrey 2002a; Zeleke 2004, Burden, 2008). Therefore, it is important, firstly, to establish the different meanings of these two interchangeable terms. Self-concept, previously defined in section 3.7.1 by Marsh and Salveson (1985) as a person's self-perception of him or herself, formed through experience with and interpretations of one's environment. In contrast, self-esteem is defined as the extent to which an individual considers that their present self matches up to their ideal self (Coopersmith 1967). Blascovich and Tomaka (1991) described self-esteem as the sum of evaluations across salient attributes of one's self or personality. In other words, how individuals perceive themselves as they are against an ideal image of what they would want to be. Self-concept, rather, considers the perceptions of one's self in relation to others formed through previous experiences and interpretations of those experiences.

Socio-cultural theory suggests that a person's sense of identity will inevitably be influenced by what is valued within society and culture (Kozulin 1998; Kozulin et al. 2003). Burden (2008) suggested where literacy is a highly valued skill, a perceived inability to acquire that skill is highly likely to have a negative impact upon an

individual's conception of him or herself as competent. As previously highlighted in Chapter 2, Snowling (2000) argued that reading is a skill highly valued by society and in most communities holds the key to education. Brunswick (2012) also argued that the difficulties dyslexics face are a result of the structures and mores of society rather than a deficit in the person.

There is increasing evidence that the underlying cognitive impairments and consequent literacy difficulties persist into adult life for those individuals with severe to moderate degrees of dyslexia (Bruck 1985, 1992; Miles 1986; Rack et al. 1992; Van Ijzendoorn & Bus 1994). Riddick et al. (1999) argued that adults with dyslexia, especially those in high literacy demand situations, such as FE and HE, still encounter a range of literacy difficulties but question whether this impinges upon their self-esteem and general well-being. A number of research studies have focused on the relationship between academic self-concept, academic attainment, academic self-esteem and global self-esteem (Bear et al. 1997; Burden 1998). However, other influences such as gender, development stage, post-academic achievement and parental attitude need to be considered alongside academic attainment and low self-esteem (Ridsdale 2004). However, Gross (1997) argued for the chronic disappointment experienced by a child with reading problems that can translate psychologically into a generalised sense of diminished value and potential. Lewandowski and Arcangelo (1994) also identified that continuing feelings of failure whilst at school can have life-long debilitating effects on an individual's ability to cope with stress.

The research surrounding dyslexia and self-esteem is limited (Patton & Polloway 1992). Burden (2008) argued that much of the literature that does exist is from the

United States (US), but there are a number of UK published research studies that explore this area (Riddick et al. 1999; Ridsdale 2004; Humphrey 2004). However, the greater majority of this research explores children with dyslexia rather than adults (Gjessing & Karlsen 1989; Butkowsky & Willows 1980). Riddick et al. (1999) also identified that a large part of the US research focuses upon students who are categorised as 'learning-disabled'; a category that encompasses a wide range of learning difficulties, including those who would be generally be classified in the UK as dyslexic. Therefore, such research might not always be completely comparable with UK dyslexia/self-esteem research. However, can the findings of this research transcend to adults with dyslexia?

A study by Gerber et al. (1990), which explored whether persistent problems of adults with learning disabilities continue into adulthood, claimed that evidence from a wide range of individuals whose ages span the full range of adulthood indicates problems experienced during school years can be the very same problems experienced in adulthood. However, in contrast, other studies have argued that childhood literacy problems do not always have the same impact in adulthood (Fitzgibbon & O'Connor 2002). Riddick et al. (1997) tentatively suggested that the cognitive and functional difficulties experienced by dyslexic children do indeed persist into adulthood but that the negative emotional experiences do considerably reduce once individuals have left the competitive and high literacy demands of the school environment.

Fitzgibbon and O'Connor (2002) argued that the effects of dyslexia change considerably as the individual gets older and the needs of adult dyslexics are considerably different from the needs of child dyslexics. However, in contrast Riddick

et al. (1999) also suggested that adults in higher education (HE), which is still a competitive and high literacy demand environment, still report a number of negative feelings. As previously highlighted in section 3.4.2, which explored dyslexia amongst students in HE, there is evidence of negative attitudes towards dyslexic students amongst academic staff, though also evidence of positive support and understanding amongst other staff. Additionally, through the rise in the national strategy of inclusive learning and teaching in HE, also highlighted in section 3.4.2, it might be envisaged that the support, understanding and overall well-being of the disabled student in HE might improve.

Riddick et al. (1999) undertook a study that investigated the personal well-being of a group of 16 dyslexic students against a control group of assumed non-dyslexic students at the same UK University. Using a culture free self-esteem inventory scale, the dyslexic group had significantly lower self-esteem scores than the control group. Additionally, both student groups were asked to rate their written work compared with their ability at both primary and secondary school. The dyslexic group were more likely than the controls to rate their written work as underestimating their overall ability. They also rated how anxious they were about schoolwork compared with their peers; 15 of the 16 dyslexic students rated themselves as more or very much more anxious, whereas 13 of the control group rated themselves as average or less than average in anxiety compared with their peers.

Riddick et al. (1999) concluded that the low self-esteem of the dyslexic students as a group matched closely with the overall picture they gave of their past and present learning experiences. However, it was unclear whether low self-esteem was a primary

link to the students' present performance and experiences or whether past negative experiences continued to have an adverse impact on self-esteem. A Canadian study (Saracoglu et al. 1989), undertaken on a sample of 65 students at a Canadian university, 34 of which were classified as having a learning disability (LD), found that the LD students, despite being quite motivated, did not display positive attitudes regarding their competence per se. However, other research reveals a variability surrounding dyslexia and low self-esteem. Kloomok and Cosden (1994) and Hagborg (1996) found that some dyslexic children maintained healthy self-esteem in the face of academic failure by perceiving themselves as successful in other areas such as sport or as enjoying high levels of social support. However, it is difficult to surmise whether these positive outlooks continue into adulthood in such individuals. Fitzgibbon and O'Connor (2002) argued that literacy weaknesses, when present in adults with dyslexia, are largely irrelevant to the individual's occupational success.

The evidence presented in this section appears to identify some links between dyslexia and low self-esteem. However, the research surrounding dyslexia and low self-esteem is limited, particularly in adults with dyslexia. Ridsdale (2004) noted that the subject of self-esteem and self-concept is very much rooted in evidence-based psychology. From the perspective of this study, one of the aims is to explore the influences that shape both the professional and educational experiences of nursing students with dyslexia, which might consider the student's own self-esteem and perceptions about themselves.

### **3.8 Summary of Chapter Content**

This chapter has presented a systematic review of the literature surrounding dyslexia and nursing, outlining three distinct literature searches during the period of the development of my study, specifically 2012, 2015 and 2016. These three literature searches aimed to review current and past literature, but also to review recent literature, which presented the most current view surrounding this topic. The following summary presents an overview of the literature review.

Firstly, what is apparent from this literature review is the significant rise in numbers of students with dyslexia entering HE. Students with dyslexia account for around half of all self-reported disabilities in HE (HEFCE 2016) and it is the most frequently self-declared disability in HE in the UK (Mortimore & Crozier 2006). It can be surmised that the advent of UK disability legislation in 1995, the subsequent SENDA Act in 2001 and the later Equality Act in 2010 is one possible reason for this rise in numbers. However, as highlighted, this legislation might also be a trigger for the rise in research surrounding disability and HE, but more specifically, dyslexia and nursing, which saw the first UK study in 2000 with a number of subsequent studies thereafter (see Table 3.2). The literature revealed variable levels of support and understanding offered to students with dyslexia and other disabilities at university, with evidence of a lack of understanding about disabilities, including dyslexia, and a lesser level of support amongst some academic staff (Cameron & Nunkoosing 2012; Evans 2014). However, in contrast, there was also evidence of exceptional levels of support and understanding to the needs of the disabled student (Lukianova & Fell 2016; Atabey 2017).

A number of research studies exploring dyslexia and nursing, revealed the variability of difficulties that nursing students and nurses with dyslexia experience in clinical practice. However, it was noted that only a limited number of studies had explored dyslexia amongst registered nurses. Difficulties identified amongst these studies were specific aspects of documentation, drug administration, remembering large amounts of information, giving clinical handovers (Illingworth 2005; Morris & Turnbull 2006, 2007b; Price & Gale 2006; White 2007; Crouch 2008; Ridley 2011; Sanderson-Mann & Wharard 2012; Ikematsu et al. 2014). However, some commonalities were identified surrounding specific difficulties as indicated in Table 3.5, specifically memory tasks, documentation, drug administration and nursing tasks such as clinical handovers. It is significant to note that a number of studies that explored nursing and dyslexia make comparisons against a non-dyslexic sample of nurses (Price & Gale 2006; Child & Langford 2011; Murphy 2011; Sanderson-Mann et al. 2012). This revealed the non-dyslexic sample similarly experienced difficulties in specific clinical tasks such as drug calculations, aspects of drug administration and clinical handovers. Such findings are of interest as it suggests the nursing students in the non-dyslexic sample experience similar difficulties as the dyslexic sample to a greater or lesser degree, which begins somewhat to blur the boundaries of dyslexia, but also might suggest some nursing students maybe undiagnosed dyslexics.

A number of research studies explored the role of the mentor in supporting the nursing student with dyslexia (Illingworth 2005; Morris & Turnbull 2006, 2007a, 2007b; Price & Gale 2006; Crouch 2008; Ridley 2011; Sanderson-Mann et al. 2012). These studies' findings revealed positive support for dyslexic nursing students from nurse mentors, but also, in contrast, evidence of negative and discriminatory reactions to dyslexia by

mentors. Evidence of negative reactions to dyslexia amongst some mentors might indicate the presence of a stigma surrounding dyslexia within certain areas of undergraduate nurse education. The negative perceptions by mentors can potentially strongly influence the disclosure of dyslexia by nursing students and nurses. It is significant that there has been no research exploring the perceptions of dyslexia amongst nurse preceptors. Additionally, there are only two studies that have explored dyslexia amongst registered nurses (Illingworth 2005; Morris & Turnbull 2007a), which indicates a limited amount of research in this area, identifying a significant gap in the research, requiring further exploration.

The disclosure of dyslexia in clinical practice is a complex concept and cannot be simply divided into those who disclose and those who do not disclose their dyslexia; rather, the decision to disclose can be dependent upon previous experiences, concern for safety, the culture of the clinical environment and the supportive nature of a mentor. Evans (2013) identified three broad categories of nursing students' positioning of their dyslexic identity: embracer, passive engager and resister, which significantly influence the true detail and extent of disclosure.

The literature review highlighted a number of concerns surrounding nurses with dyslexia, mainly through letters published in nursing journals, which raised the issue of safety in relation to the nurse with dyslexia (Duffin 2001; Watkinson 2002). The larger majority of these concerns was for the most part anecdotal in nature, but they do add to the ongoing dyslexia discourse highlighted in this chapter. There is currently no empirical evidence to suggest that a nurse with dyslexia is unsafe to practise (Wright 2000; Morris & Turnbull 2006). However, as highlighted in this review, the cases of two

dyslexic nurses suspended from the nursing register by the NMC for reasons of either incompetence or serious clinical errors places safety concerns surrounding dyslexia and nurses further under the microscope. This is reinforced by negative media coverage surrounding these cases (Burton Mail 2008). As highlighted in this chapter, such cases cannot be generalised to all dyslexic nurses.

This chapter explored the concepts of self-perception, self-concept, self-esteem and identity in relation to dyslexia, firstly identifying the different meanings of these diverse terms. The self-perception of the nursing student and nurse with dyslexia is clearly an area of study that requires further exploration. Identity and the self-perception of dyslexia remains an under-researched area of study. The study by Evans (2013), which explored the self-perception of dyslexia amongst dyslexic nursing students, provided a unique insight into how nursing students with dyslexia perceive themselves. One of the significant findings from this study was the contemporary constructions of dyslexia, focusing upon elements such as their creativity and their eagerness to be the same as other students (Evans 2013). A number of studies that explored the attitudes of mentors towards nursing students with dyslexia revealed some negative attitudes amongst mentors (Illingworth 2005; Morris & Turnbull 2006, 2007a, 2007b; Price & Gale 2006; Crouch 2008; Ridley 2011; Sanderson-Mann et al. 2012). It is argued such negative attitudes might impact upon the self-perception of a nursing student with dyslexia. Fitzgibbon and O'Connor (2002) argued how difficulties experienced by dyslexic employees in the workplace can result in the affected person being judged unfairly by others.

There is some evidence of low self-esteem amongst dyslexics; however, much of this research mainly focuses upon children (Butkowsky & Willows 1980; Gjessing & Karlson 1989). There remains debate on whether low self-esteem and dyslexia continues into adulthood. A number of research studies focused on the relationship between academic self-concept, academic attainment, academic self-esteem and global self-esteem (Bear et al. 1997; Burden 1998). However, Ridsdale (2004) argued that other influences such as gender, development stage, post-academic achievement and parental attitude need to be considered alongside academic attainment and low self-esteem. A number of studies have explored links between low self-esteem and dyslexia amongst students in the UK and Canada (Saracoglu et al. 1989; Riddick 1999), but these studies were inconclusive in making a direct link between the impact of dyslexia and self-esteem. Therefore, generalisations of low self-esteem cannot be made to every adult with dyslexia, and this remains an area for further debate and research.

The position of the NMC surrounding dyslexia and disability is explored in this chapter, outlining the development of a number of key NMC documents, which present guidelines surrounding the entry of applicants onto a pre-registration nursing programme. The advent of the Equality Act in 2010 saw a change in the tone of these documents, moving away from a medical model of disability type dialogue, with reference to requests for evidence of a disability from a GP, to greater emphasis on equality and diversity, reiterating the importance of equality and fairness in the selection of candidates. However, it was highlighted in the NMC document *Good Health and Good Character* – a guide for educational institutions (2010c) that educational institutions themselves should decide upon what reasonable adjustments

are required for a nursing student or nurse. It is argued that such a policy might have a resultant effect of differing approaches amongst institutions on how they implement reasonable adjustments. Additionally, the investigation by the Disability Rights Commission in 2007 into the impact of fitness standards on disabled people in nursing, teaching and social work found evidence of systemic discrimination within the nature of the regulatory fitness requirements, which further adds to the debate of the treatment of disabled employees. The question remains, has the Equality Act (2010) reduced or even eliminated such discrimination? To answer this question in part, this chapter has highlighted evidence of some discrimination towards students with dyslexia in a number of studies within the HE environment amongst a number of university lecturers (Cameron & Nunkoosing 2012; Evans 2014; Atabey 2017).

### **3.9 Development of Research Questions from the Literature Review**

From the summary of the literature review, a number of themes from the review have begun to emerge, which are summarised as follows:

1. Contrasting negative and positive views and perceptions of dyslexia by nurse mentors
2. Differing and complex reasons for disclosure or non-disclosure of dyslexia by dyslexic nursing students and nurses
3. Wide range of contrasting difficulties experienced by nursing students/nurses with dyslexia
4. Limited research surrounding registered nurses with dyslexia
5. No known research on preceptors' perceptions or experiences of dyslexia and nursing

6. The NMC's position on dyslexia and reasonable adjustments
7. Limited research on the self-perception of dyslexia amongst dyslexic nursing students and nurses
8. Limited research on the perceptions and experiences of nurse lecturers about dyslexia and nursing
9. Some evidence of low self-esteem amongst those with dyslexia

These findings identify a number of gaps in this area of research where only limited or no known research currently exists, specifically registered nurses with dyslexia, self-perception of dyslexia amongst nursing students, preceptors' perception of nurses and dyslexia and nurses and nurse lecturers' perceptions of dyslexia.

A PhD thesis is required to make an original contribution to knowledge (Philips & Pugh 2005). Therefore, in the preparation of such a project, it is important to identify gaps or evidence of limited research in an area of study, as listed one to nine at the beginning of this section. These elements, on closer inspection, involve a number of stages surrounding a dyslexic nursing student's journey from nursing student to registered nurse. These stages involve specific groups of individuals who guide and support them along this journey, namely the nurse tutor at the university, the nurse mentor in clinical placement and the preceptor during their first six months of qualification, as well as the NMC who regulate competence and eventual nurse registration. This journey might be viewed on a continuum where the nursing student develops professionally, educationally and clinically along this line, and the tutor, mentor and preceptor who support them contribute both directly and indirectly to their educational and clinical development and eventual professional registration. As has been highlighted in the literature review, a nursing student/registered nurse with dyslexia might experience

difficulties in practice as well as potential discrimination or negative reactions from others. As the dyslexic nursing student passes through this transition from student to a registered nurse, they face a number of experiences along this developmental journey. This journey is unique to each nurse with or without dyslexia.

The initial thoughts and the early development of my research questions began prior to the formation of this literature review and prior to commencing my PhD studies. This was influenced by the completion and outcomes of my MA thesis *To explore the impact of dyslexia amongst nursing students and their own personal experiences whilst on clinical placement* (Greaney 2007), as outlined in Chapter 1. At the closure of this study, further questions, prompted by myself, surrounding nursing students with dyslexia in practice focused initially upon support from mentors in the context of dyslexia and undergraduate nursing, as my MA thesis did not involve questioning either mentors or preceptors. Rather, the study relied upon narrative experiences from the nursing students about their own experiences of their mentors, reported by the study participants as either positive or negative. This initiated the following three questions:

- 1. *Is dyslexia constructed negatively amongst some mentors in practice?***
- 2. *What is the level of support from mentors towards nursing students with dyslexia?***
- 3. *What is the level of understanding and acceptance of dyslexia from mentors towards dyslexic nursing students in clinical practice?***

These questions further aligned with point one of the themes, which emerged from the literature review:

Contrasting negative and positive views and perceptions of dyslexia by nurse mentors

This led me also to consider preceptors as the literature review acknowledged there was no evidence of research that had explored preceptors' perceptions of dyslexia, noted as point five of the emerging themes from the literature review:

No known research on preceptors' perceptions or experiences of dyslexia and nursing

Therefore, a further question was developed concerning nurse preceptors in the context of dyslexia who support newly registered nurses in their first six months of registration:

***4. How do preceptors perceive dyslexia through supporting a newly qualified dyslexic nurse in clinical practice?***

There were a number of influences, which prompted my interest in pursuing research surrounding registered nurses with dyslexia. Firstly, at the conclusion of my MA thesis, I began to consider whether anything changes once a nursing student with dyslexia becomes qualified with regard to their dyslexia. As my MA thesis had only explored nursing students with dyslexia, I began to reflect on further study, hence my consideration of registered nurses with dyslexia. Additionally, point four of the emerging themes from the literature review acknowledged the limited research concerning registered nurses with dyslexia:

Limited research surrounding registered nurses with dyslexia

I therefore developed a further question, which considered the registered nurse with dyslexia:

***5. Do the experiences of a dyslexic nursing student change following registration as a qualified nurse?***

I then began to reflect upon the suspension from the nursing register of two nurses with dyslexia, highlighted in section 3.6.1 'Safety and the Nurse with Dyslexia'. I first read the details about these suspensions during the first year of my PhD studies. I recall feeling shocked and surprised in sudden recognition that two nurses were suspended as a direct result of the difficulties they experienced due to their dyslexia. These incidents left me questioning what actually happened to these nurses as nursing students, why were the difficulties they were experiencing which led to their suspension not identified when they were students? Additionally, when considering the wide range of difficulties experienced by nursing students/nurses highlighted in point three of the literature review themes:

Wide range of contrasting difficulties experienced by nursing students/nurses with dyslexia

These reflections prompted a number of further questions surrounding the nursing student with dyslexia:

***6. To what degree do difficulties associated with dyslexia vary amongst nursing students with dyslexia in practice?***

- 7. Do dyslexic nursing students have specific strategies to tackle their difficulties in practice that result from their dyslexia?**
- 8. Do these strategies differ from one nursing student to another?**
- 9. How effective are these strategies? Are they effective in ensuring safe and efficient practice?**
- 10. Is safety and fitness for practice a concern surrounding a nurse with dyslexia in clinical practice?**

These questions were also based on my thoughts at the end of my MA thesis, which focused on the difficulties faced by nursing students with dyslexia as well as the strategies they might use to overcome these difficulties. However, question nine surrounding safety and fitness for practice, was one question amongst the others listed from my thesis findings that I presented at a Royal College of Nursing (RCN) research conference in 2008. One member of the audience reacted quite angrily to this question on safety and the dyslexic nurse, challenging me that suggesting a nurse with dyslexia was unsafe in practice was both unfair and discriminatory. This reaction surprised me, and my first response after was to remove the question from my presentation, so as not to upset or offend anyone else. However, afterwards on reflection, I felt this issue really raises some strong and emotive feelings and needed exploring further, hence my pursuit of this topic as part of a PhD study. Developing these questions prompted me to consider further whether these difficulties continue post registration, and to question how preceptors perceive dyslexia through their support of dyslexic registered nurses, as previously highlighted in question four:

- 11. Do difficulties associated with dyslexia continue to qualification as a registered nurse, amongst final year nursing students with dyslexia?**

From these initial 11 prima facia questions, I began to formulate more direct questions, alongside my initial thoughts and questions that I had developed earlier as follows:

**1a How does the support and perception of mentors and preceptors of a nursing student with dyslexia differ once they are a registered nurse?**

**1b To what degree does the support given by mentors and preceptors as well as their perceptions differ and change towards a nursing student with dyslexia in clinical practice through to a nurse with dyslexia once registered?**

Both of these questions were focusing on mentor and preceptors' perceptions but one fault I felt with these questions was the wording appeared to assume that support given by mentors and preceptors did differ, when prior to any data collection, there was no evidence that this was the case.

At this point, I then became interested in discourses, which were influenced by reading the narrative voices of nursing students and nurses with dyslexia from a number of empirical research studies on this subject. Further reading around discourses, including the work of Foucault, led me to critical discourse analysis and the construction of discourses, which began to change significantly the formation of my research questions as follows:

**2a What are the professional and educational experiences of nursing students with dyslexia in clinical practice and how do these experiences change as they adapt and learn to work during the transition to a registered nurse with dyslexia?**

**2b What constructs the perceptions and understandings of dyslexia amongst those who support and guide dyslexic nurses through clinical practice both at a pre-registration and post-registration level?**

I was now quite confident in these questions and proceeded to present them at a STORIES Conference at the School of Education, University of Oxford in March 2012. I had constructed these questions as I had begun to realise my study was proposing to explore a number of aspects of dyslexia and nursing from a number of perspectives, including nursing student to registered nurse, mentor and preceptor. The inclusion of these multiple perspectives led me on to the use of case study research, which introduced me to the concept of the singular case, as discussed further in Chapter 4 (Methodology and Design).

Following discussion with my supervisor, the structure and wording of my research questions resulted in a differently worded question (3a), including the words 'influences' and 'shapes' rather than just 'what', but still having similarities to question 2a. Additionally, I reflected upon some of the complex elements and influences surrounding a nursing student with dyslexia, which emerged from the literature review data, specifically differing and complex reasons for the disclosure of dyslexia, evidence of low self-esteem amongst some with dyslexia and limited research surrounding self-perception of dyslexia amongst dyslexic nursing students and nurses.

**3a What influences and shapes professional and educational experiences of nursing students with dyslexia in clinical practice and how might these influences and experiences change/be changed as they adapt and learn to work as a registered nurse with dyslexia?**

Question **2b** was also reworded removing 'constructs', (3b); constructionism will be discussed in some detail in the methodology and design chapter and will be incorporated within the analysis of the data. Additionally, I dismissed the use of critical discourse analysis as I found it to be very linguistically based, analysing every word and utterance, presenting a highly complex analytical tool I had no experience of.

**3b What are the perceptions, experiences and understandings of dyslexia amongst those who support and guide dyslexic nursing students/nurses through education and clinical practice both at a pre-registration and post-registration level?**

Bringing these questions up to date at the end of this literature review chapter, I took the opportunity to look at the whole structure of all the research questions again. My observations presented me with indications that question **3a** was quite broad and did not fully or immediately indicate the data that would be necessary to answer the question. Punch (2000: 28) argued that a well-developed and well-stated research question indicates what data will be necessary to answer it. Punch (2000) described this inclusion of data in research questions as an empirical criterion. The data, namely nursing students with dyslexia, was not immediately apparent at the beginning of the question. Therefore, I rephrased the question in the following version (4a) with the new included words highlighted:

**4a What do nursing students with dyslexia think influences and shapes their professional and educational experiences in clinical practice and how might these influences and experiences change/ be changed as they adapt and learn to work as a registered nurse with dyslexia?**

This question clearly states nursing students with dyslexia at the very beginning of the question and sets out the empirical data from the start.

In the same context, question **3b** on closer observation also did not clearly state the data necessary to answer this question, namely mentors, nurse tutors and preceptors and again was rephrased to include as Punch (2000) described 'empirical criterion'. Therefore, the question was reworded to version 4b, again with the new included words highlighted:

**4b What are the perceptions, experiences and understandings of dyslexia amongst mentors, nurse tutors and preceptors who support and guide dyslexic nursing students/nurses through education and clinical practice both at pre-registration and post-registration level?**

A further research question emerged when I considered the position of the NMC surrounding nurses with dyslexia highlighted in this literature review chapter, specifically evidence of a number of contentions in their professional position regarding the issue of disabilities amongst nursing students and nurses. The statement made by the NMC in their document *Good health and good character: guidance for educational institutions* (2010c) appears to give responsibility over to the programme providers as to what constitutes a reasonable adjustment. It is argued such a position may result in a lack of uniformity amongst programme providers setting their own regional decisions on such matters. Closer analysis of these documents has the potential to reveal in more depth the position of the NMC on these matters. Additionally point six of the emerging themes from the literature review, as outlined in section 3.9, noted the NMC's position on both dyslexia and reasonable adjustments.

Therefore, from these thoughts and observations and in the context of these collective arguments surrounding the NMC's position, a further research question (5a) emerged:

**5a What is the professional position of the Nursing and Midwifery Council surrounding dyslexia in nursing and nurse education and how is this presented through its national standards and guidelines?**

However, on closer observation it was noted this question failed to specify clearly the specific data to be analysed. Punch (2000) stressed the importance of the inclusion of data within the research question or empirical criterion, to provide clarity to a research question. Therefore, the amended version (5b) has the inclusion of the word documents, clearly stating the specific data to be explored:

**5b What is the professional position of the Nursing and Midwifery Council surrounding dyslexia in nursing and nurse education and how is this presented through its national standards and guideline documents?**

In summary, following a process of development of thoughts and ideas from an initial pre-PhD phase through to alignment with the findings of my literature review and subsequent grappling and rewording of the research questions outlined, the three research questions separated into two parts in questions 1 and 2 are currently stated as follows:

**Research Question 1a**

**What do nursing students with dyslexia think influences and shapes their professional and educational experiences in clinical practice?**

### **Research Question 1b**

**How might these influences and experiences change/be changed as they adapt and learn to work as a registered nurse with dyslexia?**

### **Research Question 2**

**What are the perceptions, experiences and understandings of dyslexia amongst mentors, nurse tutors and preceptors who support and guide dyslexic nursing students/nurses through education and clinical practice both at a pre-registration and post-registration level?**

### **Research Question 3a**

**What is the professional position of the Nursing and Midwifery Council (NMC) surrounding dyslexia in nursing and nurse education?**

### **Research Question 3b**

**How is the professional position presented through the NMC's national standards and guideline documents?**

## **3.10 Chapter Summary**

This chapter has presented a systematic literature review of key literature surrounding aspects of dyslexia and nursing. The chapter presented a historical overview of UK nurse education to place this topic into context and followed with a critical discussion of areas of research that have explored the experiences of the nursing student and nurse with dyslexia in the university and clinical areas. Additionally, this chapter has presented a critical discussion of areas of relevance in relation to this topic including

competence, safety, self-concept and self-esteem. This systematic review and critical discussion of the literature has identified a number of gaps in areas of this research and a need for further study, which has led to the development of five research questions. The research design and approach to this study will be further developed and discussed in the Chapter 4 – Methodology and Design.

## **CHAPTER 4: Methodology and Design**

### **4.1 Introduction**

The previous literature review chapter concluded by highlighting a number of significant gaps in the research on the topic of dyslexia and nursing, as well as highlighting evidence of limited amounts of research in some areas of study. This led to the development of five research questions as outlined at the end of Chapter 3. This chapter outlines the methodology and describes the methodological elements of this study including my ontological and epistemological position, as well as any philosophical considerations and underpinnings that have influenced my overall research design and the specific methods of analysis.

### **4.2 Context of the Study**

This study took place across two UK higher education (HE) institutions where undergraduate nursing programmes are undertaken. The sample comprised six nursing students from these two institutions, with a recognised diagnosis of dyslexia in the final six months of their undergraduate nursing programmes. The study re-visited these same six nursing students six months after nurse registration.

One of the key objectives of this study is to explore in depth the professional and educational experiences of these dyslexic nursing students during their transitional journey to registered nurse, as well as identifying influences that might shape these experiences. As has been highlighted in Chapter 3, dyslexic nursing students are faced with a number of difficulties in clinical practice, and on occasion some experience

negative and derogatory attitudes towards their dyslexia in both practice and university settings (Morris & Turnbull 2006; Price & Gale 2006; White 2007; Ridley 2011; Evans 2013; Crouch 2017).

In this context, this study aims to explore the experiences of the six dyslexic nursing students both at university and then in practice as registered nurses, and to determine whether anything changes in relation to their dyslexia. Also, from a universal perspective, this study aims to obtain a 'snapshot' of dyslexia in nursing and nurse education through a number of multiple elements and perspectives. This is not only from the perspective of the dyslexic student nurse during their transitional journey to becoming a registered nurse, but also through the experiences and perceptions of the nurse tutor, the mentor and preceptor, namely those who support and guide them through this journey. Additionally, the study aims to examine the professional position of the Nursing and Midwifery Council (NMC) in relation to dyslexia in nursing through its standards, and policy and guideline documents, which outline, shape and guide disability policy within the nursing profession from the student admission stage throughout a nursing career.

All these multiple elements outlined were explored collectively using a case study method. Case study method is defined as a specific kind of research that focuses on one thing as a whole and does not seek to generalise from it (Thomas 2011). The inclusion and justification of the case study method is outlined in greater depth in section 4.4 of this chapter. From these multiple elements, the aim of this study is to gather a comprehensive depiction of dyslexia within nursing and nurse education.

### **4.3 Sample of Participants**

As highlighted in the previous section, the sample of participants for this study were six nursing students recruited from two UK higher education institutions (HEI) in the last six months of their undergraduate nursing programme. Additionally, the sample also comprised nurse tutors, mentors and preceptors who guided these same nursing students through the transitional journey from nursing student to registered nurse. This section details this sample of participants recruited to this study, outlining the sampling criteria and recruitment process.

#### **4.3.1 Nursing Students**

The six nursing students were recruited from two UK HE Institutions; four came from the first HEI and two from the second HEI. For the purposes of accuracy, and for later reference to the study results in subsequent chapters, the first HEI from where four nursing students were recruited will be referred to as HEI 1 and the second, where two nursing students were recruited will be referred to as HEI 2. The rationale for the use of two HEIs is outlined later in this section. Prior to any contact being made with the nursing students, ethical approval was sought from each HEI to approve the methods chosen to collect data from them. In addition, permission was sought from the head of the school of nursing from each HEI, including approval of the adopted method to initiate first contact with nursing student participants. A further detailed discussion of the ethical process of this study will be elaborated on in section 4.4 of this chapter.

The number of study participants was agreed at six with my supervisor. The determinant for a sample number is dependent upon a number of factors including the type of research adopted and whether your aim is to obtain a large representative

sample of your chosen population for your study. The type of research method, as previously highlighted, is the case study method. Stake (1995) described case study as the study of the particularity and complexity of a single case. In respect of the complexity of a single case, the aim is to focus specifically on that case and no other. The focus in this study is dyslexia in nursing and nurse education, the spotlight being on the specific participants highlighted at the beginning of this section. Therefore, the aim was never to obtain a representative population of nursing students with dyslexia.

Thomas (2011) describes a sample in a case study as more of a selection than a sample and there should be no expectation that it represents the wider population. Additionally, the analytical approach to this study is through interpretative phenomenological analysis (IPA), later discussed in section 4.7.6 of this chapter. IPA is an ideographic approach and is concerned with the understanding of a particular phenomenon in particular contexts; as such, IPA studies are conducted on small sample sizes (Smith et al. 2009). It is suggested by Smith et al. (2009) that between three and six participants can be a reasonable sample size for a student IPA project. The recruitment of the nursing students for this study ensured they met specific criteria according to the objectives and context of the study. The inclusion and exclusion criteria for the recruitment of nursing students to this study were as follows in Table 4.1

**Table 4.1 – Inclusion and exclusion criteria for recruitment of nursing students**

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"><li>• A registered diagnosis of dyslexia from a registered dyslexia assessor</li><li>• Student nurse who is dyslexic and is currently in approximately their final six months of a pre-registration nursing course</li></ul>	<ul style="list-style-type: none"><li>• No evidence of a registered diagnosis of dyslexia</li><li>• Student nurses who are not currently in their final six months of their pre-registration nursing course</li></ul>

The rationale for seeking a registered diagnosis of dyslexia is to ensure the participants hold a registered diagnosis of dyslexia from an educational psychologist, rather than the participant simply reporting independently they had dyslexia, ensuring validity of the sample of the study. The requirement that the student nurse participants were within their final six months of a pre-registration nursing course, was to ensure a stable flow in the longitudinal element of the study through to the first six months of registration.

Recruitment of the nursing students from the first HE institution (HEI 1) was initially through access to the university database of students with disabilities and identifying those who were nursing students with dyslexia in their final six months of their undergraduate nursing course. This approach was following ethical approval by the ethics department of the university in question who approved this specific approach. Six nursing students who met the study inclusion criteria were identified from the database. These students were contacted through written correspondence from the researcher, accompanied by a study participant information sheet, outlining the details

of the study (Appendix 6) and a consent form (Appendix 10). The participant information sheet stated clearly, 'You are not obliged to take part in this study and are free to refuse'; therefore, no participant was under any obligation to take part in this study.

Out of the six students who were contacted, four returned their consent form agreeing to take part in the study. As highlighted at the beginning of this section, the number of six nursing students was set as the final agreed sample number. Therefore, following the recruitment of four nursing students from the first HE institution, there was a need to recruit a further two nursing students to fulfil the final agreed sample number, thus two HEIs were chosen for this study rather than one. A second HE institution (HEI 2) was approached to recruit further nursing students with dyslexia for this study. This university, as part of the ethical approval for this study, required me to recruit participants using an online flyer and for any potential participants to contact myself directly by e-mail (Appendix 16). Following the placing of this flyer on the students' university online platform, I received e-mails from two students who expressed an interest in participating in this study. As with the students from the first university, I e-mailed a study participation sheet (Appendix 6) and consent form (Appendix 10). Both of these students consented to take part in the study. Therefore, the target sample of six nursing students had now been reached. Table 4.2 provides a data summary of the nursing students who consented to participate in this study:

**Table 4.2 – Summary of the nursing students recruited for this study**

<b>Student Name (Pseudonym)</b>	<b>Gender</b>	<b>Under-graduate Nursing Branch</b>	<b>Ethnicity</b>	<b>Age of Dyslexia Diagnosis</b>	<b>Final Year Placement</b>
Emma (HEI 1)	F	Adult	British Caucasian	28	Walk-in Centre
Holly (HEI 1)	F	Adult	British Caucasian	26	Medical Ward
Marie (HEI 1)	F	Adult	African	10	Intensive Care Unit
Lucy (HEI 1)	F	Learning Disability	British Caucasian	8	Learning Disabilities Assessment Unit
Olivia (HEI 2)	F	Adult	British Caucasian	9	Orthopaedic Ward
Chloe (HEI 2)	F	Child	British Caucasian	22	Paediatric Admissions Ward

With reference to Table 4.2, the nursing students recruited for this study came from a variety of nursing branches including learning disability, child and adult, which nationally many UK universities do offer as part of their undergraduate nursing courses. Three of the students received a diagnosis of dyslexia as children and three received their diagnosis as adults. All the students were female; this might be expected

in accessing a small sample of UK nursing students, as current NMC figures for 2015/16 report 64% of nurses are female and 36% are male (NMC 2016a).

#### **4.3.2 Mentors**

There was a need for the mentors who participated in this study to have a direct clinical placement connection to the nursing student participants for the purposes of speaking of their own experiences with that same student and to explore their own perceptions of dyslexia in relation to that experience. This meant that each mentor had to have recently worked with the student participants and been assigned as their mentor in a recent clinical placement area. The method that was used to access these specific participants was to ask each student participant at the end of their first interview with the researcher to provide the name of a mentor on their most recent or current placement. This mentor was then contacted by letter and sent a participant information sheet outlining the details of the study (Appendix 7) and consent form (Appendix 10). Out of the six mentors contacted, only four consented to participate in the study. Table 4.3 provides a data summary of those mentors who chose to participate in the study and the connection to the student nurse participants in Table 4.2:

**Table 4.3 – Mentor participants recruited for this study**

<b>Mentor Identity &amp; Student Connection</b>	<b>Gender</b>	<b>Clinical Placement Area</b>
Mentor 1A (Emma)	M	Walk-in Centre
Mentor 2B (Holly)	F	Medical Ward
Mentor 3C (Lucy)	M	Learning Disabilities Assessment Unit
Mentor 4D (Marie)	F	Intensive Care Unit

#### **4.3.3 Nurse Tutors**

The recruitment of the nurse tutors for this study was conducted in the same manner as in the recruitment of the mentors. As with the mentors, the nurse tutors had to have the same direct connection to the nursing students in this study, specifically the nurse tutors had to be the university personal tutor to the students. This was to provide the opportunity for the tutors to speak of their own experiences of tutoring the same student nurse who was participating in the study as well as speak of their own perceptions of dyslexia. Similarly, the nursing students were asked at the end of their first interview to provide the name of their personal tutor at their associated HEI. The tutors were then contacted by letter and sent a participant information sheet outlining the details of the study (Appendix 8) and a consent form (Appendix 10).

However, one tutor from HEI 2 did not wish to take part in the study. As previously detailed in section 4.3.1, the participant information sheet clearly stated, 'You are not obliged to take part in this study and are free to refuse'; therefore, no participant was under any obligation to take part in this study. However, in view of the small sample size, and after discussion with my academic supervisor, a decision was made to contact the course director of the specific nursing course the nursing student was part of and request their participation in the study. Similarly, contact was made with the course director by letter, accompanied by a participant information sheet and consent form, and they consented to take part in the study. Additionally, one of the nursing students (Emma) from HEI 1 was one of my personal students; therefore, it was impossible to conduct an interview when in this case, the researcher and the personal tutor were one in the same person. In such circumstances, the course director was contacted again using the same approach as previously highlighted, by letter accompanied by a participant information sheet and consent form, and they agreed to participate. These highlighted issues relating to the researcher's position will be further discussed in section 4.8.2, Positionality. Table 4.4 provides a data summary of the nurse tutors who consented to participate in the study and the connection to the student nurse participants in Table 4.2:

**Table 4.4 – Nurse tutor participants recruited for this study**

<b>Tutor Identity &amp; Student Connection</b>	<b>Gender</b>	<b>HEI &amp; Position</b>
Tutor 1A (Emma)	F	HEI 1 (Course Director)
Tutor 2B (Holly)	F	HEI 1 (Personal Tutor)
Tutor 3C (Lucy)	M	HEI 1 (Personal Tutor)
Tutor 4D (Marie)	F	HEI 1 (Personal Tutor)
Tutor 5E (Olivia)	F	HEI 2 (Personal Tutor)
Tutor 6F (Chloe)	M	HEI 2 (Course Director)

#### **4.3.4 Preceptors**

The criteria used to recruit mentors and nurse tutors were also used to recruit the preceptors for this study. Specifically, at the point of the study where the nursing students became registered nurses they were asked to provide the name of their assigned preceptor in their current workplace. Similarly, as with the recruitment of the mentors and nurse tutors, the named preceptors were then contacted by letter and sent a participant information sheet outlining the details of the study (Appendix 9) and

a consent form (Appendix 10). All but one of the preceptors consented to participate in the study. The preceptor assigned to Lucy had left the clinical area where they worked and contact with them could not be made. Table 4.5 provides an overall summary of the data of the preceptors who consented to participate in the study and their connection to the six nurse participants:

**Table 4.5 – Preceptor participants recruited for this study**

<b>Preceptor Identity &amp; Student Connection</b>	<b>Gender</b>	<b>Clinical Workplace</b>
Preceptor 1A (Emma)	M	Medical Admissions Ward
Preceptor 2B (Holly)	F	Medical Admissions Unit
Preceptor 3C (Lucy)		<i>Left clinical area and contact could not be made</i>
Preceptor 4D (Marie)	F	Surgical Ward
Preceptor 5E (Olivia)	F	Medical Ward
Preceptor 6F (Chloe)	F	Intensive Care Unit

### 4.3.5 Registered Nurses

Following nurse registration, the six nursing students in this study gained employment in a number of hospitals around the UK. As part of the longitudinal element of this study, the six nurses will be interviewed again, approximately six months following registration to explore their experiences as a registered nurse with dyslexia. Table 4.6 outlines their clinical areas of employment:

**Table 4.6 – Registered nurses’ areas of employment**

<b>Student Name (Pseudonym)</b>	<b>Clinical Workplace</b>
<b>Emma</b>	Medical Admissions Ward
<b>Holly</b>	Medical Admissions Unit
<b>Marie</b>	Surgical Ward
<b>Lucy</b>	Adolescence Learning Disabilities Unit
<b>Olivia</b>	Medical Ward
<b>Chloe</b>	Paediatric Intensive Care Unit

### 4.4 Ethical Considerations

The ethics surrounding research data is a vital and significant consideration of any research project. Robson (2011) highlighted the potential for stress, harm and anxiety as possible consequences for those who participate as subjects of research. Thomas (2009) commented on the importance of respect for others and the principles of conduct about what is right and wrong within the research arena.

As this study is longitudinal in design, it underwent a series of stages for ethical approval; firstly from the specific universities or HEIs where the nursing students and nurse tutors were located, and then the NHS hospitals where the registered nurses, mentors and preceptors were located. The first phase of the study involved interviews with the nursing students and secondly their nurse tutors. As has already been outlined in the section concerning sampling (section 4.3), four nursing students from HEI 1 consented to participate, which did not meet the target sample of six, thus a second HEI had to be approached to recruit two further students. Therefore, an ethical application had to be made to each separate HEI. Ethics applications were made initially to HEI 1 AND HEI 2. Ethics approval was received from both universities and confirmation of this approval can be found in the appendices (HEI 1 Appendix 19/20, HEI 2 Appendix 21).

The two universities requested different approaches regarding how the students should be recruited, as briefly outlined in section 4.3. HEI 1 approved my ethical access to the university database to identify nursing students who were dyslexic and were in their final six months of their nursing course. Once identified, these students were contacted directly by letter accompanied with a participant information sheet (Appendix 6) and consent form (Appendix 10). HEI 2 required that the nursing students from their institution be recruited by means of an online flyer (Appendix 16). The participant information sheet provided clear information about the details and nature of the study and the participant's role, additionally it clearly stated, 'You are not obliged to take part in this study and are free to refuse'. This fulfils the standards and principles of informed consent.

Parahoo (2006: 329) defines informed consent as 'The process of agreeing to take part in a study based on access to all relevant and easily digestible information about what participation means, in particular, in terms of harms and benefits.' Additionally, informed consent requires specific information about the research including the details about the purpose of the research, how long will it last and who is involved. As previously detailed in section 4.3, the nurse tutors had to have a direct connection to the nursing students in the study by the nature of being the student's personal tutor. Following recruitment of and confirmed informed consent from the nursing students, the nurse tutors were also contacted by letter by the researcher with an accompanying participant information sheet (Appendix 8) and consent form (Appendix 10).

Along with the nurse tutors, the mentors were also part of phase one of the research. However, as mentors are employees of their respective NHS trusts, an ethics application was made to the Local Research Ethics Committee (LREC) so approval from each NHS Trust could be sought. The mentors, in line with the nurse tutors, had to have a direct connection to the nursing students in the study, each being assigned as a student's mentor in their clinical placement area.

Phase two of the research involved the same nursing students as in phase one, who had now become registered nurses. Each had gained employment as registered nurses at particular NHS trusts around the UK. Therefore, a further application was made to the LREC so the individual NHS trusts where each nurse was now employed could be contacted to apply for ethical approval to interview each nurse as part of this study. Each NHS trust had different approaches to the ethics process; some were happy to grant approval following receipt of the research documents including the

LREC application, and participant information sheet and consent form. One NHS trust required me to attend a research ethics panel prior to any ethics approval. Additionally, as part of phase two of the study, the preceptors from each NHS trust, who were supporting the newly registered nurses in their first six months, were contacted following ethical approval and sent a participant information sheet (Appendix 9) and consent form (Appendix 10).

One of the key principles of research ethics is the protection of the research participants, specifically that they do not experience any physical or psychological harm either during or after their participation in a research study. Long and Johnson (2007) argue that all research can be potentially harmful to participants and researchers. As my research study involves interviewing nurse participants in contrast to patients, the first thought would be that the risk of harm during a research interview to a participant or the researcher is very low.

However, despite this inferred risk of harm being low, it cannot be completely dismissed. Firstly, the consideration should be the vulnerability of the research participants. The phrase, 'people who are vulnerable' may encompass a multitude of populations (RCN 2009). The participants in this study, namely nursing students with dyslexia, nurse tutors, mentors and preceptors would not be automatically labelled a 'vulnerable group' nor should it be considered a label or applied as a blanket term to specific groups (RCN 2009). However, in making an ethical application, consideration should always be made of potential harm. Specifically, any one of the participants in this study could potentially become distressed in speaking about their own experiences. A particular consideration here is the nursing students potentially

speaking of a negative experience they might have had as a direct or indirect result of being dyslexic. Therefore, as part of an ethical application, such potential events should be a key consideration. In view of this, I highlighted that if any participant did become distressed as a result of their participation in this study, counselling services should be offered from their affiliated institution or organisation.

A further important principle of ethics in research is that of confidentiality, both to the research participants and to their associated organisations. It clearly states in each participant information sheet given to each participant group, 'You will not be identified in the study by name. Any information collected about you will be kept confidential and any personal information such as your name will be anonymised.' In protecting the identity of both the research participants and the organisations they are part of ensures their anonymity will be protected at all times. Therefore, the nursing students were given a pseudonym and the mentors, nurse tutors and preceptors a prefix such as 1a, 2b etc. as detailed in section 4.3. Similarly, the identity of the organisations such as the universities and hospital trusts are not revealed in the overall results.

The protection of research data is a vital consideration in research ethics. Therefore, according to the HEI 2 ethics regulations, all data pertaining to this study should be stored in a locked cabinet and computer-stored data on a password encrypted hard drive. The requirements of these research data regulations were maintained throughout the study. Additionally, all participant data should be stored for five years following completion of the study and destroyed thereafter.

## 4.5 Case Study

As described in previous sections, the chosen approach to this study is case study. This section describes the case study approach and provides the rationale for this choice of research method, as well as discussing the theoretical elements underpinning this approach.

Thomas (2011: 3) stated that ‘when you do a case study, you are interested in that thing in itself as “a whole”’. Thomas goes on, ‘what is of interest is the uniqueness of the thing and the thing in its completeness’ (2011: 3). With this in mind, my study aims to explore a picture or depiction of dyslexia in nursing and nurse education from a number of perspectives and sources, initially from the experiences of the dyslexic nursing students and their progression to registered nurse. Secondly, from the experiences, thoughts and perceptions of mentors, nurse tutors and preceptors both at university and in clinical practice settings; and thirdly, from the contents of a number of key NMC regulatory documents. Thus, the aim is to examine dyslexia in nursing and nurse education from a variety of different perspectives. This is one particular characteristic of case study research in that different methods, as well as different participants, are used to gather data and in doing so, a more in-depth picture is formed of the subject under study. This use of differing methods in research is characterised as triangulation. Triangulation is defined as viewing things from more than one perspective (Denscombe 2010) and will be discussed in more depth in section 4.8.6 of this chapter.

Thomas (2011) argued that the assumption with a case study is that with a great deal of intricate study, looking at our subject from many and varied angles, we can get closer

to the 'why' and 'how'. Foucault (1981) described such an approach as 'a polyhedron of intelligibility'; that is, he felt inquiries in the humanities and social sciences were often one-dimensional. However, viewing a subject from a variety of directions provides a more rounded, richer, more balanced picture of the subject, and so a more three dimensional view becomes apparent (Thomas 2011).

Through this three dimensional view, case studies strive to portray 'what it is like' to be in a particular situation, to catch up the close up reality and 'thick description' of participants' lived experiences of thoughts about and feelings for a situation (Geertz 1973). This 'thick description' and the feeling of 'what it is like' to be in a particular situation is what I strive to seek from my study from the perspective of a nurse with dyslexia in practice and their progression to registered nurse.

The key component of any case study is the unit of analysis. Yin (2009: 30) described the unit of analysis as, 'your basic definition of the case'. Wieviorka (1992: 160) argued, 'For a case to exist we must be able to identify a characteristic unit ...but it has no meaning in itself. It is significant only if an observer ...can refer to an analytical category or theory.'

The unit of analysis in this particular case study is dyslexia in nursing and nurse education. The analytical category or objects referred to here in the context of this study are the professional experiences, perceptions and understandings of dyslexia within the nursing profession. These professional experiences, perceptions and understandings were gathered from the study participants, namely dyslexic nursing students, mentors nurse tutors and preceptors, as well as secondary resources namely

key NMC documents. Essentially one of the aims of this study is to build a theory around dyslexia and nursing.

Thomas (2011: 112) described building a theory as about developing, almost from scratch, a framework of ideas, or a model that somehow explains the subject you are researching. In this context, there have been a number of research studies highlighted in the literature review chapter, which have explored dyslexia and nursing from a number of perspectives from the nursing student or the registered nurse with dyslexia to the mentor or nurse tutor (Illingworth 2005; Sanderson-Mann & McCandless 2005; Morris & Turnbull 2006; White 2007; Ridley 2011; Evans 2013, 2014). Therefore, it might be arguable that this study is truly starting from 'scratch', in light of previous research on the subject. However, based on my literature review there is no evidence of a study that has followed the transition of a nursing student with dyslexia through to nurse registration and thus examined a holistic picture of dyslexia and nursing. Rather, this study aims to explore collectively a number of perspectives examined in previous studies. Therefore, through theory building, it is hoped, a new unexplored theory or theories surrounding dyslexia and nursing might emerge as well from a broader perspective surrounding higher education.

This study was undertaken on two research sites initially. This is characteristic of case studies in the context of the 'drill deep' philosophy as described by Thomas (2011). Similarly, Stake (1995: 11) described that case study is the study of the particularity and complexity of a single case. The singular case is an important aspect of case study in that the focus is very much on a singular area or organisation, individual or group of individuals, rather than a multiple group of elements. The aim of a case study is not to

make comparisons but more importantly, not to make generalisations. Thomas (2011: 13) reinforced this key aspect of case studies: ‘...there can be no assumption that the case is any way representative of a wider whole – it is a one off, defined by the peculiar circumstances that you the researcher, describe’.

In this context in relation to this study, the universities and affiliated hospital trusts and the participants that took part, the findings from these collective sources will not and cannot be generalised. It would be inappropriate to state that the study’s findings can be generalised in relation to the depiction of dyslexia and nursing and nurse education across the UK to other institutions. Rather, the findings are offered for others perhaps to make inferences, to gain insight or to open up further debate surrounding this area of study, but not as an example, which can be generalised.

#### **4.6 Theoretical Framework**

A theoretical framework is defined broadly as the theory behind the research. It is also referred to as the theoretical perspective. Essentially, the theoretical framework is the ‘nuts and bolts’ of the theoretical and philosophical basis of a research study. In introducing the theoretical framework to my study, there is a need to consider my research questions outlined in Chapter 3, to examine them in terms of what they are asking as well as what theoretical and philosophical paradigms are the most appropriate fit. Paradigms, as described by Thomas (2009), are positions on the best ways to think about and study the social world; therefore, what best approach should be adopted to begin to answer my research questions.

On closer examination of the wording and general objectives of these questions, what begins to emerge are some of the theoretical and philosophical underpinnings

embedded within them and thus, what knowledge is required in answering these questions. Here we are taking an ontological view, which helps us to identify and differentiate between different sets of understanding and viewpoints about our research (Cleaver et al. 2014). In this context we ask what we are looking at as well as what viewpoint are we looking at it from. We are also determining what knowledge we hope to seek from this study, taking a broader epistemological view of the knowledge of how we know things or concepts from this study. Cohen et al. (2011) described epistemology as being viewed as one set of assumptions made about the world and being concerned with the very basis of knowledge.

In the context of the epistemological view, the first two research questions (1a & 1b) are seeking the experiences, understandings and perceptions of people, namely nursing students with dyslexia who later become registered nurses. Question 2 seeks the experiences and perceptions of mentors, preceptors and nurse tutors who support them through this academic and clinical journey. People, by their very nature, are unpredictable; each might see the world differently from one another, think differently and act differently in particular situations and thus view the world from different perspectives. This view supports the position of Cohen et al. (2011), which contrasts the differing viewpoints of knowledge; one being hard, objective and tangible, the other as knowledge being personal, subjective and unique rejecting the laws of natural science.

Thus, in this respect, the knowledge we seek about dyslexia within nursing and nurse education from the views and knowledge of others, might, considering Cohen et al.'s (2011) epistemological view of knowledge as one set of assumptions of the world, vary

from one person to another. Each might interpret dyslexia in different ways either having dyslexia themselves or having worked with someone with dyslexia. This knowledge is dependent upon a number of elements, particularly how dyslexia is interpreted and how the participants of this study construct it. The two terms 'interpretation' and 'construction' are very significant here and identify some of the underpinning philosophies of this study.

Constructionism is an epistemological position within the field of social research (Crotty 1998). Social Constructionism is how humans make sense of and construct the world around them. Crotty (1998: 44) stated that according to constructionism, we do not create meaning, we construct meaning. In this context, meaning is the objects around us and the objects within our world. In relation to this study and most specifically, dyslexia, are the perceptions and understandings of dyslexia socially constructed? As highlighted in section 3.6.1 of the literature review, there is evidence of anecdotal and negative language surrounding dyslexia by mentors as well as press reports highlighting safety concerns regarding dyslexia and nurses; therefore, this is just one example of how dyslexia may be socially constructed through others and the media.

Herrington and Hunter-Carch (2001) argued that dyslexia is a social construct. However, to delve deeper into the principles behind constructionism, the work of Heidegger and Merleau-Ponty echo strongly with constructionism in that they repeatedly state the world is already there and the objects within that world are what we construct meaning to. In this context, the historical origins of dyslexia, outlined in Chapter 2 claim the first recognition of dyslexia was in 1676 identified by physician John Schmidt, and later in the nineteenth century, the term 'word blindness' was first

used by German neurologist Adolf Kussmaul to describe dyslexia; a term still used to this day. Later in the nineteenth century, the word dyslexia was introduced by Berlin in 1887, meaning difficulty with words. Therefore, in support of Heidegger and Merleau-Ponty's argument, it is posited that the world was already in existence. In this context it can be argued that dyslexia has been in the world all along, but it took man to recognise it, give it an identity and label it and thus socially construct it.

In this historical context, Crotty (1998: 64) argued that historical and cross-cultural comparisons should make us very aware that at different times and in different places, there have been and are very divergent interpretations of the same phenomena. This is true in that social constructionism will change with time and vary dependent upon culture and changing attitudes. However, an exploration of culture and dyslexia are beyond the limits of this study, rather the attitudes of others towards dyslexia are of particular interest.

The literature review has already highlighted the contrasting negative and positive views or attitudes surrounding dyslexia in nursing; therefore, there is evidence of how dyslexia is socially constructed through the voices and perceptions of others. Evidence of these contrasting world views are supported by Crotty (1998) who reiterated the need for recognition that different people may well inhabit different worlds and for these people their different worlds will constitute diverse ways of knowing, with distinguishable ways of meaning and separate realities, meaning all of us might interpret the world differently.

As highlighted earlier, the term interpretation is a significant term in relation to this study in how dyslexia is both interpreted and constructed. Interpretivism is an

ontological view and completely opposes the views of natural research scientists who believe the social world can be obtained objectively. Schwandt (1994: 125) argued that interpretivism was conceived in reaction to the effort to develop a natural science of the social world. Interpretivism is closely linked to constructionism as claimed by Crotty (1998). What constructionism claims is that meanings are constructed by humans, as they engage with the world they are interpreting. The main principle of interpretivism is its interest in people and the way they interrelate, what they think and how they form ideas about their world, essentially how their world is constructed (Thomas 2009), hence the inextricable link to constructionism. However, in this study, interpretivism and its use in research not only apply to the research participant, but also the researcher in the sense that it is adopted to interpret the views of the participant and also to recognise the researcher's own views or position. In other words, how your own experience, background, views, opinions and attitudes impact upon your own interpretation of the research. This is also a key characteristic of phenomenology, which too is an interpretivist research concept adopted as a key element of the theoretical perspective of this study. The researcher's position will be detailed further in section 4.8.2 Positionality.

The word 'phenomenology' is derived from the Greek word 'phainomenon' meaning appearance (Holloway & Wheeler 2002). It is believed the German philosopher Immanuel Kant first used the word in the eighteenth century (Spiegelberg 1984). Phenomenology is a broad qualitative methodology, which constitutes distinct types and global schools of thinking surrounding it including the German and Dutch school and the American school, for example. Denscombe (2010: 95) provides a broad definition of phenomenology: '...to see things through the eyes of others, to understand

things in the way they understand things...how the group (or individual) in question experiences the situation’.

The key elements of this definition that identify what phenomenology is about are the seeing of things through the eyes of others, and to understand things in the way they understand them, rather than from the researcher’s perspective. In other words attempt to step away from your own preconceptions and view something through the eyes of another. However, the researcher’s perspective is also significant as outlined earlier in the discussion of the principles of interpretivism. Crotty (1998) described this attempt to describe people’s subjective experience of ‘putting oneself in the place of the other’, sometimes styled as the ‘great phenomenological principle’. Crotty (1998: 83) went on to describe that the emphasis typically remains on common understandings and the meanings of common practices, so that phenomenological research of this kind emerges as an exploration, via personal experiences, of prevailing cultural understandings.

The prevailing cultural understandings or the overall culture described here in relation to my own study is the nursing profession and nurse education as a whole. Any organisation or profession can be described as a culture and can be defined as the way of life as a group – the learnt behaviour that is socially constructed and transmitted (Holloway & Wheeler 2002). However, in exploring the cultural understandings of dyslexia in nursing and nurse education, my aim is not to determine a cause of the attitudes, perceptions and experiences of the participants. Rather, my aim is to view the perspectives, perceptions, experiences and understandings of nurses with dyslexia

and those who support them or, in other words, view the phenomena of dyslexia in nursing and nurse education. Valle and King (1978: 15) stated:

...by asking the question, 'What?', that is, he or she seeks to understand phenomenon in their perceived immediacy and is not concerned with explaining, predicting or controlling them – the question, 'Why?' is not asked as this question implies an underlying causal view of the world.

The basis of this concept returns to the 'phenomenological principle'; rather than directing attention to why a phenomenon occurred, the emphasis instead focuses upon trying to depict the experiences that are as faithful to the original as possible, that is the raw experience or the lived experience.

Phenomenological research is the study of the lived experience and aims at gaining a deeper understanding of the nature or meaning of our everyday experiences (Van Manen 1998: 9). The lived experience of the dyslexic nursing student who later progresses to become a registered nurse is the key basis of this study. From a secondary perspective, are the lived experiences of the mentors, preceptors and nurse tutors, as well as their overall perceptions and understandings of dyslexia. As Van Manen (1997) explained, phenomenology differs from other research disciplines in that it does not aim to explicate meanings specific to culture or social groups, for example, rather the meanings as we live them in our everyday existence or our lifeworld. In this sense, however, it should be stated that we are not observing these experiences as they occur through observation, for example. Rather, we are reflecting upon the experience after it has occurred.

As Van Manen (1998) argued, phenomenological reflection is not introspective, it is retrospective in that reflection on experience is always re-collective; it is reflection on

experience that has already passed or been lived through. From this perspective, my study aims to allow the research participants to reflect upon and talk about their previous experiences as a nursing student/nurse with dyslexia and in a similar manner allow the mentors, preceptors and nurse tutors to also reflect and talk about their experiences from their own perspective.

In Chapter 2, I referred to the Frith (1995) shared framework for dyslexia, suggesting its use in providing a basis for viewing and characterising perspectives of the nurse with dyslexia. Frith's framework also assists in attempting to add context to the multi-perspectives of the nursing student/nurse with dyslexia.

This section has presented an overview of the theoretical framework that encompasses the three research elements of my study, namely social constructionism, interpretivism and phenomenology. Additionally, it has revisited my research questions and attempted to link ontologically and epistemologically the three research elements into these questions, noting what knowledge is sought as well as how we can seek this knowledge through exploration of the lived experience of the research participants.

## **4.7 Methodology**

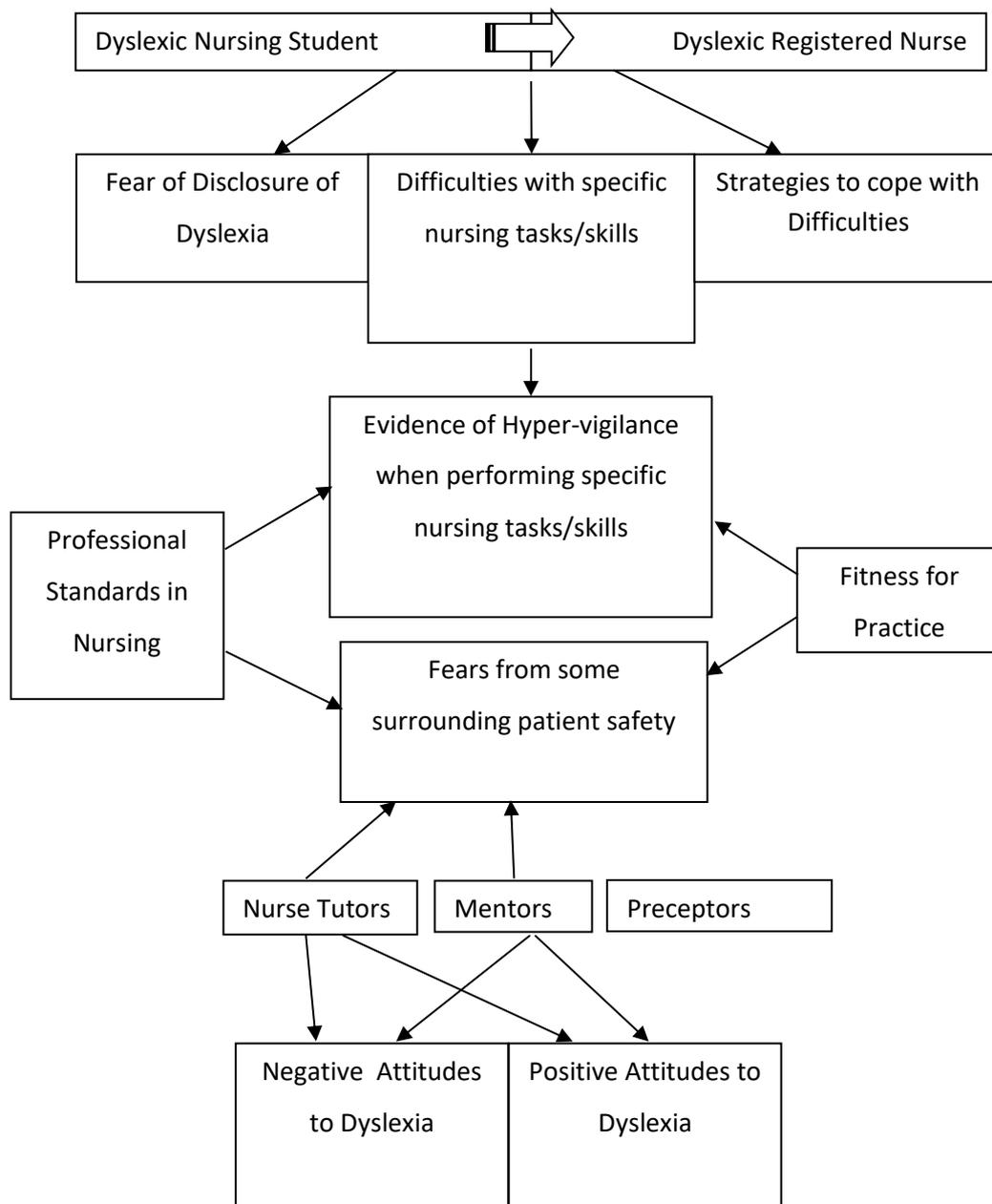
Methodology, is defined by Thomas (2009) as the study of method, a discussion of the methods you will use as well as the reasons for using your chosen methods. Crotty (1998) described methodology further as a strategy, plan of action, process or design, which lies behind the choice and use of particular methods. Holloway and Wheeler (2002) described it as an underlying rationale and framework of ideas and theories, which determines what approaches, methods and strategies are to be adopted. Therefore, there exist various descriptions of what methodology is. However, what can

be determined from these multiple definitions is that methodology is about both method and how method is utilised as part of a research project. The methodology of my research is described as follows.

As briefly highlighted in the introduction and the literature review, my initial research study thesis for my MA (Greaney 2007) explored the impact of dyslexia on nursing students in clinical placement. The key findings from this study were the difficulties the nursing students with dyslexia faced in practice, the strategies they employed to help them cope with these difficulties, a fear amongst some to disclose their dyslexia and a lack of understanding amongst some of their mentors about dyslexia, to some degree, for fear of patient safety. Additionally, as was also highlighted in the introduction, there currently exists limited research surrounding registered nurses with dyslexia, which presented scope for further and deeper research into this area. Furthermore, my literature review added additional context and detail to some of these issues in terms of differing experiences of nursing students with dyslexia; evidence of hypervigilance amongst dyslexic nursing students as well as differing attitudes, both positive and negative, by mentors towards those with dyslexia.

From these observations emerge a sizable picture of a group of individuals who are gathered together by the very nature of their chosen profession and who interact and work together within a professional work setting, which is guided by professional standards and regulations. However, by the circumstances of being dyslexic, they are faced with what is often described as a learning difficulty, which has the potential to cause friction for some, including a lack of awareness and a lack of understanding by one section of this group (mentors, preceptors, nurse tutors), as well as difficulty and

fear amongst the other section (dyslexic nurses). In addition, dyslexia may have the potential (some believe) to a greater or lesser degree to compromise a nurse's ability to perform effectively as a nurse in practice, highlighted in the literature review. There are also present a number of other factors that became apparent in the literature review, namely evidence that many nurses with dyslexia demonstrate hypervigilance when performing clinical tasks. This somewhat challenges the negative view of dyslexia by some who claim that a nurse with dyslexia may be a threat to patient safety. The following diagram (Figure 4.1) places all these elements and ideas discussed into context:



**Figure 4.1 – Diagrammatic representation of the differing factors highlighted in the literature review that form the exploratory elements of my study**

The arrows in this diagram link to the findings of the literature review, which identified evidence links between elements; for example, evidence of both positive and negative attitudes of mentors towards dyslexia as well as fears of both nurse tutors and mentors

surrounding patient safety. Note there is no arrow linking preceptors' attitudes to dyslexia, as there is no current literature available. A number of these elements in this diagram might be viewed as 'pushing and pulling' forces, contradicting or challenging each other, such as the opposing negative and positive attitudes about dyslexia amongst mentors and the fears surrounding patient safety contradicted by the evidence of hypervigilance amongst nurses with dyslexia. Further challenges to this are the professional issues of fitness for practice referring to the suspension of two registered nurses with dyslexia from the professional register identified in the literature review, as well as the maintenance of professional standards in practice. These elements might be described as a maelstrom of forces and elements swirling around clashing with each other where no finite conclusion can currently be reached. However, what are not apparent in this diagram are the actual experiences of these groups or individuals, their actual voices, conversations surrounding dyslexia, their thoughts, opinions and their own perceptions of dyslexia within nursing.

All these elements are evident in a wider context of human interaction, but particularly that of language. As stated by Crotty (1998: 87), 'Language is pivotal to, and shapes the situations in which we find ourselves enmeshed, the events that befall us, the practices we carry out and through all this, the understanding we are able to reach.'

Essentially one of my aims is to establish how dyslexia is spoken of within nursing and nurse education. However, my focus is not upon the specific language from either a linguistic or discourse analysis approach, rather through the broader context of experience and understanding, specifically the phenomenological lived experience.

The key participants in this study, namely the final year dyslexic nursing students who later advance to become registered nurses have their own individual and personal experience yet to be revealed. It might be predicted that not one singular experience of each participant might be alike; firstly by its very nature dyslexia presents itself in affected individuals very broadly with a variety of difficulties, but also by the uniqueness of the human experience. It is hoped these experiences when recounted in this study begin to reveal a degree of understanding of dyslexia in nursing and nurse education but also collectively through the experiences of the mentors, preceptors and nurse tutors. The recounting of their experiences as well as their thoughts and perceptions of dyslexia, will further add to this understanding.

## **4.8 Design Frame**

The design of any research study is crucial to its overall plan and structure. Thomas (2011) described a research design or design frame as a 'super structure' that supports the research. I described the 'theoretical framework' earlier in section 4.6 with the three elements of theory that form the 'nuts and bolts' of the study: social constructionism, interpretivism and phenomenology. In this same context, the design provides the girders that make up this structure and thus form its physical elements holding the study together. Analogies apart, the research design contains essentially the methods and approaches adopted for this study.

### **4.8.1 Interpretative Phenomenological Analysis (IPA) and Phenomenology**

The analysis of research data remains a key part of a research study, defined as a significant tool in seeking out what the data reveals, as well as acting as a starting point to begin to provide tentative answers to the research questions. In this context the

following provides a discussion of interpretative phenomenological analysis (IPA) (Smith et al. 2009), the chosen method of analysis for this study. The choice of phenomenology highlighted in the theoretical framework section of this chapter in broad terms means seeing things through the eyes of others and through their lived experience and has by its very name an inextricable link to interpretative phenomenological analysis.

IPA is concerned with the detailed examination of the human lived experience. It aims to conduct this examination in a way that as far as possible enables that experience to be expressed in its own terms rather than according to a predefined category (Smith et al. 2009). Smith et al. (2009: 32) provided a further description of the theoretical basis of IPA: 'IPA also pursues an ideographic commitment, situating participants in their particular contexts, exploring their personal perspectives and starting with a detailed examination of each case before moving onto more general claims.'

It is important to situate IPA in the context of this study and the theoretical framework. Firstly, when people engage with 'an experience' of something, whether this is a major or life changing experience, they begin to reflect on the significance of this and IPA research aims to engage with these actual reflections. However, experience is a very broad term; thus, what kind of experience is actually being sought here, certainly in the context of my own study and IPA? IPA is mainly concerned with experience, which is of a particular moment or significance to the person (Smith et al. 2009). From this perspective, the actual journey from a nursing student to a registered nurse is a very significant moment for any individual who experiences this, as I personally can verify. However, if you add dyslexia to this experience with the difficulties experienced by

nurses with dyslexia and a number of negative reactions towards dyslexic nurses that have already been highlighted in the literature review, this experience may take on even greater significance. IPA is also concerned very much with the personal experience of the participant. Smith et al. (2009) described experience as, 'tantalising and elusive' and argue that pure experience is never accessible; we witness it after the event. Therefore, the role of the researcher is vital here in terms of making sense and meaning of what the participant has told them, as stated by Smith et al. (2009: 36):

...the researcher is not the participant, she/he only has access to the participant's experience through what the participant reports about it, and is also seeing this through the researcher's own experientially-informed lens. So in that sense, the participant's meaning-making is first order, while the researcher's sense-making is second order.

This sense making and meaning making places IPA very much within an interpretative methodology. In this context, interpretivism is one of the three key theoretical elements of this study; thus, the IPA researcher is in part wanting to adopt an 'insider's perspective' (Conrad 1987) and see what it is like from the participant's view and stand in their shoes. However, Smith et al. (2009) stated that the IPA researcher also wants to stand alongside the participant, to take a look at them from a different angle, ask questions and puzzle over things they are saying, again taking on an interpretative approach.

As previously stated, the way humans interpret and give meaning to their experiences is the essence of the social world. An essence is the structure or form of the unique experience that a singular unique individual experiences. The social world or in the specific context of this study, the professional world of the dyslexic nursing student, as well as the mentor, nurse tutor and preceptor is what is being sought. However, in

searching for these essences or the core of these nurses' subjective experiences, there is a need for a specific analytical tool to not only search for but 'tease out' these essences from the data, as these essences are unique to an individual's experience. What is being considered is how that individual is actually constructing the elements of that experience. Constructionism is how we as humans make sense of or construct the world (Crotty 1998) and again is another one of the three theoretical elements of this study as well as linked to IPA and phenomenology.

As previously discussed, there is a strong likelihood that this study reveals multiple realities, that is differing experiences and perceptions from the study participants; it is from these differing realities, that similarities, differences, patterns or themes emerge. Thematic analysis is a very broad analytic approach adopted for a wide range of research studies, including IPA, used essentially to identify themes, patterns, relationships, ideas or incidents from data. In adopting thematic analysis for this study, the aim is not only to identify emerging patterns or themes from the experiences, thoughts and perceptions of the participants, but also to take an inductive approach to this analysis. An inductive approach to thematic analysis returns to the phenomenological principle as described by Crotty (1998: 83):

... [there should be] a quite single-minded effort to identify, understand, describe and maintain the subjective experiences of the respondents. It is self-professedly subjectivist in approach (in the sense of being in search of people's subjective experience).

Phenomenology is also about the study of the 'lived experience'. The lived experience is often described as quite a profound phenomenon in terms of how we live and experience life on a daily basis. Van Manen (1990) described phenomenology as a systematic attempt to uncover and describe the structures and the internal meaning

structures of the lived experience. However, this experience in phenomenology is reflected upon after the event, rather than during the experience. Thus researching the lived experience is placed as a retrospective undertaking, rather than an introspective one. Therefore, in adopting this approach, 'an insider's perspective' is sought to attempt to truly understand the past personal experiences of the dyslexia nurse as well as interpret the thoughts and perceptions of those who support and work alongside them at university and in clinical practice. The insider's perspective is a significant element of the role of the researcher in any study in relation to the relationship or connection between researcher and research participant, but specifically links to that of positionality, which will be discussed further in the following section.

A further method of analysis will be adopted to explore and examine key NMC documents to gauge a position of the NMC surrounding dyslexia and nursing, and disability in nursing and to answer research questions 3a and 3b. Grounded theory analysis is the adopted method used to interpret a variety of documents. The analysis of these specific documents will be detailed in Chapter 6.

#### **4.8.2 Positionality**

The issue of positionality remains an important consideration in modern research, particularly qualitative and interpretative research where the researcher plays a key role in the interpretation of the resultant study data. The role of the interpretative researcher is particularly significant in that the acceptance of our subjectivity in research, that is ourselves, and the acceptance of our own social background, perceptions and experiences, all influence our interpretative stance as a researcher. Thomas (2009) spoke of the researcher's biography in this context and the need to make this explicit in interpretative research.

In this context my own biography originates from working as a clinical nurse within areas such as intensive care and coronary care, where the scientific basis of knowledge was important in terms of how a range of complex medical treatments could improve a patient's illness or medical condition and could reduce, in some cases, overall mortality. As a nurse, I was also concerned with the patient's psychological care as well as physical care, but there was less time to consider the psychological impact of illness and disease, rather I was engaged in attending to their physical care needs. Therefore, the early part of my nursing career had a strong scientific foundation. It was only in later years that I came to consider more deeply the psychological impact. This came from an unexpected source and shortly after I had moved away from clinical nursing into nurse education. It was during my first few weeks in nurse education, I met a nursing student with dyslexia. My knowledge of dyslexia was very limited at this point, but what struck me particularly was the huge personal and social impact dyslexia had upon this student in both academia and clinical practice.

From this meeting developed a growing interest in dyslexia, particularly in the impact of dyslexia upon the person, which led to my first piece of social research on this subject, *To explore the impact of dyslexia amongst nursing students and their own personal experiences whilst on clinical placement*, for my MA thesis (Greaney 2007), as highlighted in Chapter 1. From this research developed a need to explore in more depth the profound personal, professional and social impact that dyslexia has upon nursing students and nurses. My employment background and influences that have impacted upon my current research have developed my interpretative stance as a researcher, whose foundations were once based around scientific knowledge and now are based upon social knowledge of the person. Knowledge is a complex element

within research and society in general. Foucault (1980) argued that knowledge is intimately connected with power and can sometimes be used to oppress, especially when knowledge is withheld. 'Knowledge is also a way of looking at the world and making sense of it' (Crotty 1998: 8), which is my objective through exploring the experiences of the nursing students, nurses and other participants in my study.

From a historical context, through the passage of time, the philosophy of knowledge has two schools of thinking, that of positivists and post-positivists. The positivist's belief is in hard objective scientific knowledge, that is scientific knowledge is based upon accuracy and absolute certainty (Crotty 2010). Positivism was first used as a philosophical position by the French Philosopher Auguste Comte (Beck 1979); however, Crotty (2010) argued he was a populariser of the word rather than its founder, with it being attributed to Francis Bacon (1561-1626) in earlier writings. Oldroyd (1986) described the impact of Comte's positivist and scientific stance stating that for him, social phenomena were to be viewed in the light of philosophical (or biological) laws and theories and investigated empirically, just like physical phenomena. However, Cohen et al. (2007: 11) argued 'where positivism is less successful is in its application to the study of human behaviour'. Crotty (1998) further described how scientific knowledge contrasts sharply with beliefs, feelings and assumptions, which have a strong roots in the subjective stance of research that is post-positivism. 'Post-positivism is not a unitary school of thought, but more a group of theorists who share some but not all of a range of views' (Robson 2011: 22). There is an acceptance by post-positivists that the theories, hypotheses, background knowledge and values of the researcher can influence what is observed (Reichardt and Rallis 1994).

From these two contrasting and dividing beliefs, my study falls very much within the post-positivist stance by the very nature of the inquiry exploring human experiences and perceptions and the life world of the participants. In exploring these complex and individual human elements, the role of the researcher takes on greater significance as the researcher's own interpretation during the process of data collection and the interpretation of that data can influence the eventual findings. In this context when the researcher reveals the findings of any research study, what needs to be determined is truth and knowledge. Truth and knowledge are inextricably linked and have a direct relationship to positivism and post-positivism in that we seek knowledge and truth in research through these very different schools of thought, whether we believe that truth can be gained objectively or subjectively.

Objective truth is outside an individual's bias, interpretations or feelings; subjective truth is based upon a person's own feelings and interpretations. Etherington (2004) argued there is no fixed or unchanging truth and truth and knowledge will change at any given time in history. Therefore, how do we know we are gaining truth? The philosophy of truth and knowing in research has remained a struggle and challenge for both scientists and philosophers over many years (Cutliffe & McKenna 2002). In struggling with truth and knowledge, we are probing epistemology, broadly defined as the theory of knowledge. Burrell and Morgan (1979) described epistemology as the very basis of knowledge, its nature and forms, how it can be acquired and how it can be communicated to others. This acquisition and communication of knowledge in research returns to the positivist and post-positivist stance discussed earlier. However, in determining knowledge in research, we need to justify the strength and trustworthiness of that knowledge.

In this sense, how might I determine the findings of this study I am undertaking are trustworthy and stand up to external scrutiny? From this perspective I am, as the researcher, taking an 'insider's perspective', almost trying to step into the participants' shoes in an attempt to understand and interpret the talk of their experiences as nursing students/nurses with dyslexia, mentors, tutors and preceptors. However, at the same time, I am also an outsider, not being a part of their world and am on the outside looking in. The terms 'insider' and 'outsider' were first pioneered by Evered and Lewis (1981). An outsider is described as a 'stranger or observer' whilst insiders are native to the settings of the research area and possess an intimate knowledge of the communities involved and their members (Merton 1972; Brannick & Coghlan 2007). The insider and outsider's perspective, relative to the phenomenological principles discussed in section 4.7.1 chosen as the analytical basis for this study, relates to the phenomenological study of people's experience in that we are attempting to consider quite deeply what the human experience is actually like. Therefore, we are attempting to observe quite closely the human experience as an outsider but at the same time trying to become an insider to truly feel what that experience is like for the participant through the participant's eyes.

As Smith et al. (2009:3), stated, 'we are trying to make sense of the participant trying to make sense of what is happening to them'. Robson (2011: 151) stated phenomenology in research 'focuses on the need to understand how humans view themselves and the world around them'; however, adding that 'the researcher is inseparable from assumptions and preconceptions about the phenomenon of the study'.

This phenomenological principle returns to the researcher's role with their detailed interaction with the participant and their own influences upon the interpretative process and how these influences might impact upon the findings, which brings into question the truth and knowledge surrounding this study. Firstly, 'the founding principle of phenomenological inquiry is that experience should be examined in the way that it occurs and in its own terms' (Smith et al. 2009: 12). Edmund Husserl, often considered the founding father of phenomenology, describes how phenomenology should involve the careful examination of human experience. Husserl argues that we must 'get back to the things themselves', that is the consciousness of the human experience, but he also refers to the obstacles in the pursuit of that consciousness (Smith et al. 2009). These obstacles he viewed to be our own attitudes, assumptions, views and opinions, anything that would get in the way of examining the human consciousness. In response to the presence of these obstacles, he put forward the concept of 'bracketing', that is to put to one side our taken for granted world in order to concentrate on our perception of that world (Smith et al. 2009).

However, Heidegger, a student of Husserl, challenged the concept of bracketing and viewed the ability to negate our experiences related to the experience under study as an impossibility. Rather, his view is to acknowledge and declare your own preconceptions first and rid ourselves of our tendency to immediately interpret. Heidegger focused on the nature of being, that is the nature of reality or ontology. In research, ontology is the question of what we are looking at (Thomas 2009). Holloway and Wheeler (2002) described ontology as concerned with the nature of reality and our knowledge about it, 'how things really are'.

In this sense, my research is exploring the experiences of nursing students with dyslexia who later go on to become registered nurses and the experiences of those who support them through this journey. How I interpret these particular participants is where I acknowledge my own preconceptions about those participants. Here I consider my own role as a nurse academic or nurse tutor in relation to these participants, which is significant, particularly when you consider how a nursing student may perceive me as a figure of authority and how this might be reflected in their responses during the interview process.

This action leads onto reflexivity, defined as 'finding strategies to question our own attitudes, thought processes, values, assumptions, prejudices and habitual actions, to strive to understand our complex roles in relation to others' (Bolton 2010: 13). In doing this we are declaring ourselves in our research; we are not just a partial observer in this process, rather we are part of the research process and our own biography matters. I have earlier outlined my own biography in this section detailing a move away from a scientific foundation of nursing towards a greater awareness of social science in the context of the personal, professional and psychological impact of dyslexia. Therefore, in this sense, this acknowledgement, this declaration of ourselves in our research is exposing our own feelings, prejudices and attitudes from the beginning, thus not allowing others to assume any bias in our findings. My role and position as a nurse tutor reflects my supportive role to nursing students, as does my additional role as a disability support tutor for nursing students with disabilities such as dyslexia.

Additionally, my role involves liaising with mentors on the practice development of nursing students. Essentially, my academic role is about the support of nursing

students and mentors in practice. Additionally, I know the students in HEI 1 personally, in the capacity of my role. Rubin and Rubin (2012) argued that people are usually more willing to talk to you if they feel some personal connection to you, which might be interpreted as trust, an important element of the interviewer/interviewee relationship. This trust can influence the responses an interviewee will give. It was highlighted previously in section 4.3.2, that one of the nursing student participants, Emma (pseudonym) is my personal student. It is argued that knowing this student in this capacity may influence the interview responses. However, in openly declaring this personal knowledge of a participant, it is argued that any potential bias or conflict of interest at this point is reduced.

In any research that involves workplace colleagues and peers, the participants may assume that the researcher already knows the answer (Delyser 2001; Breen 2007). Thus, the researcher may then have a number of presumptions that can result in difficulties with the interview and the quality of the data collected (Kanuha 2000). This familiarity with workplace colleagues and peers is a potential problem that may not become apparent until data transcripts are being reviewed (Delyser 2001). At the early transcript stage, it may become apparent that meaning might have been shared through innuendo, vague comments and incomplete sentences (Kanuha 2000). If this does occur, McDermid et al. (2014) suggested it can be corrected in subsequent interviews by the researcher listening to what has actually been said and asking questions to clarify meaning if necessary. This has been accounted for in my own study through using an iterative interviewing technique, where each interview with each participant is followed up with a second interview to probe further points made in the first interview and also to clarify meaning.

On the subject of meaning, one of the philosophical elements of my study is that of social constructionism, previously highlighted in section 4.5. In relation to dyslexia, it is argued that dyslexia might be socially constructed through the perceptions and talk of others. In this context, one of my focuses is how others socially construct dyslexia in their own experiences or in their life world. There is an inherent risk that as the researcher, I might socially construct dyslexia myself through my own social constructionism of dyslexia in interpreting the research data.

However, I return to the phenomenological principle, as described by Crotty (1998: 83), that phenomenology,

... a quite single-minded effort to identify, understand, describe and maintain the subjective experiences of the respondents. It is self-professedly subjectivist in approach, in the sense of being in search of people's subjective experience.

Additionally, the use of Interpretative Phenomenological Analysis (IPA) in my study, described by Smith et al. (2009: 36) as seeing the data 'through the researcher's own experientially informed lens. So in that sense, the participant's meaning-making is first order, while the researcher's sense-making is second order.' It is argued by Conrad (1987) that the IPA researcher is in part, wanting to take an insider's perspective to see what it is like from the participant's view. Therefore, the insider interpretative approach to IPA, it is argued, makes some effort to reduce the risk of interpreting research data from purely the researcher's perspective or own position, rather the emphasis being upon seeing the situation through the eyes of the participant.

#### **4.8.3 Collection of Data – Interviews**

As previously outlined in section 4.3, six nursing students plus their related nurse tutor, mentor and preceptor constitute the chosen sample of participants for this study.

Interviews are the chosen method of data collection for this study. Interviews are common as a method of choice for researchers favouring qualitative approaches in the discipline of psychology and social science (Potter and Hepburn 2005). Kvale (1983: 174) defined the qualitative research interview as 'an interview whose purpose is to gather descriptions of the life-world of the interviewee with respect to the interpretation of the described phenomena'.

The power of interviews in research cannot be underestimated. Cohen et al. (2007) described how an interview is not simply concerned with collecting data about life; it is about life itself, its human embeddedness is inescapable. Weiss (1994) believes that interview studies have made a great contribution to the understanding of society and human beings. The human interaction between research participant and researcher is a unique event and allows for the opportunity not just to collect data, but also to reveal a deeper understanding of that person's thoughts, feelings, perceptions and attitudes, any element which makes that person unique. However, interviews are not just conversations; interviews involve a set of assumptions and understandings about the situation, which are not normally associated with a casual conversation (Denscombe 1983; Silverman 1985). Kvale (1996: 6) described the use of interview in research as

a conversation that has a structure and purpose and goes beyond the spontaneous exchange of views as in everyday conversation and becomes a careful questioning and listening approach with the purpose of obtaining thoroughly tested knowledge.

Interviews in research come in three types: fully structured, semi-structured and unstructured (Robson 2011). As the primary objective of this study is to explore the personal experiences of the participants, the use of interviews would appear to be the most appropriate method of data collection for this study. Additionally, as IPA is a

phenomenological approach and the chosen interpretative approach for this study, as well as a requirement to extract rich data, interviews are the preferred means for collecting data in IPA (Smith et al. 2009).

In choosing a particular type of interviewing method, there is consideration of what are you determining to find out and in what context. As previously discussed in section 4.8.1, the aim is to truly understand the past personal experiences of the dyslexic nurse as well as interpret the thoughts and perceptions of those who support and work alongside them at university and in clinical practice. Therefore, there is a need to extract rich data and allow the participants to share their own experiences, thoughts and perceptions. In this context, there is a need for the participants to share openly their experiences with the researcher. In considering the three types of interview method listed at the beginning of this section, semi-structured interviews was a favourable choice of interview method for this study as it has a flexible and modified approach to the interview schedule allowing for questions to be developed or changed dependent upon the participants' responses.

Fylan (2005) commented that during semi-structured interviews, the conversation is free to take its own course and is likely to change substantially between participants, and by their very nature, semi-structured interviews can vary tremendously. Denscombe (2010: 175) commented on the flexibility of semi-structured interviews stating, 'the interviewer is prepared to be flexible in terms of the order in which the topics are considered and perhaps, more significantly, to let the interviewee develop ideas and speak more widely on the issues raised by the researcher'.

Additionally, this study takes a social constructionist perspective, as detailed in section 4.6; Fylan (2005) further commented that if you take a social constructionist perspective, a participant's attitudes would not be fixed and predetermined, but would emerge as part of the interview. This also relates to the thematic analysis in relation to the emergence of themes from the interview data, and thus the flexibility of semi-structured interviews should allow for the emergence of such themes. With direct reference to IPA, Smith et al. (2009: 57) commented that

...interviewing allows the researcher and participant to engage in a dialogue whereby initial questions are modified in the light of participants' responses and the investigator is able to enquire after any other interesting areas which arise.

Smith et al. (2009) also commented on in-depth and personal discussion in one-to-one interviews, allowing a rapport to be developed between researcher and participant.

The process of organising a logistical schedule for a research interview is an important aspect of the overall management of a qualitative research project. In determining a schedule and formation of interview questions for this study, as described by Smith et al. (2009: 57), a qualitative research interview is often described as 'a conversation with a purpose' and this purpose is implicitly informed by a research question. Therefore, the research questions previously highlighted in Chapter 3 in relation to the study participants are as follows:

#### Research Question 1a

What do nursing students with dyslexia think influences and shapes their professional and educational experiences in clinical practice?

#### Research Question 1b

How might these influences and experiences change/be changed as they adapt and learn to work as a registered nurse with dyslexia?

### Research Question 2

What are the perceptions, experiences and understandings of dyslexia amongst mentors, nurse tutors and preceptors who support and guide dyslexic nursing students/nurses through education and clinical practice both at pre-registration and post-registration level?

Smith et al. (2009: 58) further commented that the 'aim is to set up the interview as an event, which facilitates the discussion of relevant topics and which will allow the research questions to be answered subsequently via analysis'. Kvale (1996: 130) commented that 'one research question can be investigated through several interview questions, thus obtaining rich and varied information by approaching a topic from several angles'. In this context, it is vital to examine the research question in the first instance to determine what needs to be asked of the participants in the research interview.

Question 1a enquires of the nursing students with dyslexia what they think shapes and influences their educational experiences in clinical practice. There are several questions to be asked here in relation to the nursing students' experiences. Additionally, each experience is unique to each individual student, thus there may be a need to probe further on particular points or specific experiences revealed. Therefore, the construction of interview questions in such a study where the exploration of a person's life world is undertaken requires open-ended questions,

which do not make any assumptions about the participant's experiences or concerns or lead them to particular answers (Smith et al. 2009).

Kvale (1996) stated the very virtue of qualitative interviews is their openness. Robson (2011) commented on the advantages of open-ended questions in terms of their flexibility, allowing the researcher to go into more depth as well as encourage co-operation and rapport between the participant and researcher. Therefore, in creating research questions for this study, there needed to be an avoidance of closed questions, which would encourage a simple 'yes' or 'no' answer from the participant. Smith et al. (2009: 59) commented that 'questions should be prepared so that they are open and expansive; the participant should be encouraged to talk at length'.

Smith et al. (2009) further suggested types of questions to be used for in-depth interviews such as descriptive, narrative, structural, contrastive and evaluative. With reference to the number of questions for an in-depth semi-structured interview, Smith et al. (2009) suggested between six and ten questions. Others are less prescriptive in the number of questions that should be adopted for one-to-one research interviews; however, generally it can be surmised that too many questions may risk boredom and fatigue for both the researcher and participant. Therefore, the questions created for the nursing students take into account the need for open-ended questions and for flexibility during the interview process. The interview questions for the nursing students are located in Appendix 11. However, a selection of some key questions are listed below:

- How long have you known you were dyslexic?
- How did you feel at the time you knew you were dyslexic?
- Tell me about your experiences at school, with regard to dyslexia

- Did having dyslexia ever discourage you from wanting to become a nurse?

These questions were asked at the beginning of the interview to give the nursing students an opportunity to present their own personal background as a person with dyslexia, focusing on their feelings when they knew they were dyslexic, their experiences at school and specifically whether having dyslexia ever discouraged them from becoming a nurse. Some of these questions were influenced by the limited research on the self-perception amongst nursing students and nurses highlighted at the end of Chapter 3, the literature review. I also wished to give the nursing student participants some opportunity to talk at length of their own personal thoughts and feelings about having dyslexia. Additionally, returning to the phenomenological principles of exploring the lived experience or the life world, gathering rich data from these nursing students was an important consideration in the design of these initial questions. There was also an awareness of creating open-ended questions, which would initiate a longer narrative from the participants.

Further questions as part of this first interview asked specifically about their clinical experiences. Similarly, a selection of key questions are listed below:

- How important or significant is dyslexia to you in your nursing life? Are you aware of it, if so, in what ways?
- With reference to daily nursing tasks, could you tell me does your dyslexia cause you any difficulty performing any specific nursing tasks, specifically documentation, clinical handovers and drug administration?
- If they do cause you difficulty, do you have any strategies to overcome them?

- On disclosing your dyslexia, have you ever received a strong reaction to your dyslexia that you felt was positive or negative either in practice or at university or anywhere else?

These questions focusing on their clinical experiences were influenced in part by the findings of the literature review with reference to the varied difficulties with specific nursing tasks that nursing students/nurses experience in practice with a focus upon drug administration, clinical handovers and documentation (section 3.5.1). Additionally, a question surrounding the disclosure of dyslexia was an important addition with regard to the findings of the literature review that many nursing students/nurses have fears or hesitations in disclosing their dyslexia to others (section 3.5.5).

As highlighted earlier in this chapter, this study is a longitudinal study following the nursing student participants through from their final six months as nursing students into their first six months as newly registered nurses, interviewing them at these two distinct points. Research question 1b focuses on whether the influences and experiences changed as registered nurses in contrast to when they were nursing students.

**RQ 1b** How might these influences and experiences change/be changed as they adapt and learn to work as a registered nurse with dyslexia?

The registered nurses' interview questions are in Appendix 12. However, a number of selected key interview questions are listed below:

- Since you have become a registered nurse, do you feel anything has changed or is anything different in relation to your dyslexia?

- Did you have any particular concerns or anxieties starting out as a newly registered nurse?
- Were any of these concerns or anxieties related to your dyslexia?
- Are there any particular daily clinical tasks that you experience difficulty with in relation to your dyslexia as a registered nurse, specifically documentation, clinical handovers and drug administration. Anymore you wish to add?
- Have you received any particular negative reactions in practice from colleagues or others which you feel was specifically related to your dyslexia since you qualified? Tell me more about that.

It was highlighted at the end of the literature review chapter that there is limited research surrounding registered nurses and dyslexia, currently three pieces of research (Morris & Turnbull 2007a; Illingworth 2005; Major 2017). Therefore, this aspect of my study is an important addition to this body of research. One of the main focuses was if anything had changed since the nurses had become registered nurses in relation to their dyslexia. In respect of this change, a question related to difficulty with clinical tasks, which was asked of the participants when they were nursing students, was asked as to whether these difficulties remained. Additionally, the interview questions asked the participants about disclosure of their dyslexia in relation to the literature review findings of fear of disclosure amongst some nurses with dyslexia.

- Do you disclose your dyslexia to colleagues in practice or tend to keep it to yourself?
- If you don't disclose your dyslexia, what are your reasons for non-disclosure?

Research question 2 relates to the tutors, mentor and preceptor participants of the study specifically asking of them their perceptions, experiences and understandings of

dyslexia in relation to the same nursing student/registered nurse participants in the study.

**RQ 2** What are the perceptions, experiences and understandings of dyslexia amongst mentors, nurse tutors and preceptors who support and guide dyslexic nursing students/nurses through education and clinical practice both at pre-registration and post-registration level?

Each set of tutor, mentor and preceptor participants had a dedicated number of interview questions (Appendix 13-15). However, as with the interview questions for the nursing student and registered nurse participants, these were influenced by the findings of the literature review, in respect of difficulties in practice, disclosure and mentors' perceptions of dyslexia. The interview questions for the nurse tutors were focused from the perspective of their role within nurse education located at the university. The nurse tutors were an important aspect of the study as there is limited research surrounding nurse tutors' perceptions of dyslexia amongst nursing students, as highlighted at the end of the literature review chapter. The following are a selection of key questions from the nurse tutor interview questions (Appendix 15).

- What do you know about dyslexia; how would you describe or define it?
- Are you aware of any specific difficulties a nursing student with dyslexia might experience in practice?
- What are your own thoughts or perceptions about a nurse with dyslexia?
- Do you think nursing students with dyslexia are well supported at university?
- Do you think nursing students with dyslexia are well supported in practice?

These questions enquire of the nurse tutors' understanding of what dyslexia is as well as their awareness of any difficulties a nursing student might experience in practice. Additionally, two questions enquire of their thoughts on whether they think nursing students are well supported at university and in clinical practice. These, like the questions asked of the nursing students/registered nurses, are open-ended in style and allow opportunity for the tutors to talk at greater length of their thoughts, perceptions and understandings of dyslexia.

The interview questions for the mentor participants similarly to the nurse tutors ask of their understandings of what dyslexia is, but now places greater focus upon their own experience in clinical practice mentoring a nursing student with dyslexia. The following are a section of key questions from the mentor interview questions (Appendix 13).

- How would you describe dyslexia?
- You have mentored a nursing student with dyslexia, could you tell me something about those experiences
- What are your own particular thoughts and perceptions about a nurse with dyslexia in practice?
- Are you aware of any specific difficulties a nursing student with dyslexia will experience in practice?
- Many nursing students who have dyslexia are often unwilling to disclose their dyslexia to others in clinical practice. Can you understand their reasons for non-disclosure?

Similar to the tutor interview questions, the mentors are questioned on how they might describe dyslexia, presenting their own personal understanding of what dyslexia is and

asking them to talk of their own individual experiences mentoring a nursing student with dyslexia. One of the questions focuses on disclosure of dyslexia, asking if they can understand why a nurse with dyslexia may be unwilling to disclose, in relation to the research surrounding hesitancy amongst some nurses in disclosing their dyslexia, highlighted in the literature review chapter (section 3.5.5).

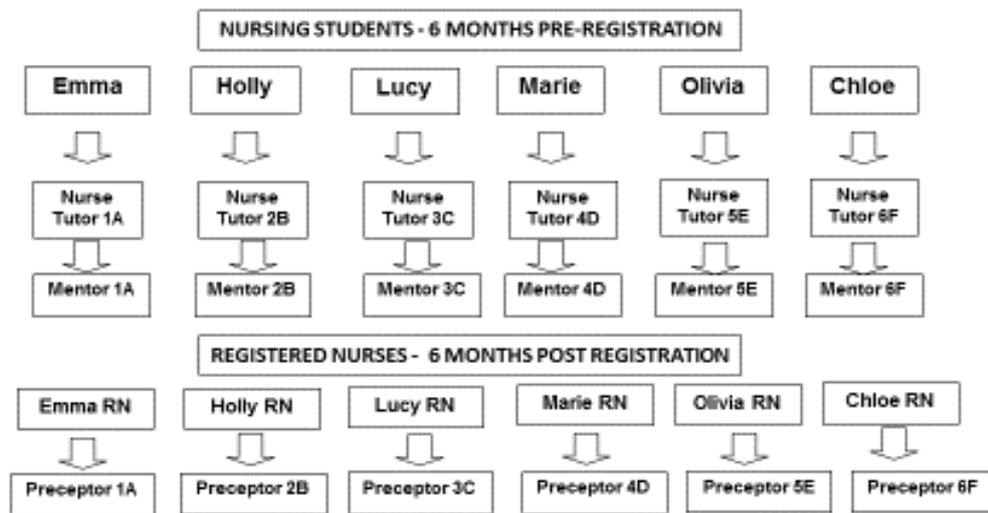
The interview questions for the preceptors, like the mentors, focus upon their experiences in clinical practice and their understandings and perceptions of dyslexia, including in relation to their experience with the registered nurse with dyslexia they had supported in practice. The following are a section of key questions from the preceptor interview questions (Appendix 14).

- What do you know about dyslexia?
- You were preceptor to a nurse who is dyslexic, could you tell me something about those experiences
- What are your own particular thoughts and perceptions about a nurse with dyslexia in practice?
- Has being a preceptor to a nurse with dyslexia changed any of your own thoughts and perceptions about dyslexia?
- Many nurses who have dyslexia are often unwilling to disclose their dyslexia to others in clinical practice. Can you understand their reasons for non-disclosure?

Similar to the style of the interview questions asked of the other participants, the questions are open-ended to allow opportunity for the preceptors to describe their experiences in some detail. Additionally, further questions concerning disclosure are included to match what is also asked of the nurse tutors and mentors.

What are not included in these interview questions are 'prompts'. Smith et al. (2009) described the use of 'prompts' or 'probing' in interview technique, emphasising the importance of these to find out more about the interesting or important things the interviewee might say. Kvale (1996) described how probing encourages further description or can be used to check clarity on particular points made by the participant. Such prompts were adopted during the interview process where specific points required further clarification or particular areas of interest required further questioning or exploration.

The interview schedule involves the interviewing of each participant at distinct points during the progression of the study. As outlined at the beginning of this section, six nursing students were interviewed at two distinct points within their final six months as a nursing student and within their first six months as a newly registered nurse. Additionally, the students' personal nurse tutors at the university, their mentors in practice placements and their preceptors in their clinical workplace were also interviewed. The interview schedule is outlined below in Figure 4.2:



**Figure 4.2 – Interview schedule**

In section 4.3 the sample of participants for this study was detailed; it was explained that the use of iterative interviewing would be adopted, with each participant interviewed on two occasions. This involves a specific method of interviewing where the researcher interviews the participant on two separate occasions to expand on points and areas of interest from the first interview. Each interview was audio recorded and transcribed following each interview. The recording and transcribing of each interview is clearly detailed in the participant information sheets (Appendix 6-9). A professional transcriber undertook the transcribing of each interview recording. Using IPA, it is recommended that the researcher should undertake the transcribing of the interview data (Smith et al. 2009). However, the number of study participants is 30 with each participant interviewed twice, increasing the potential amount of interviews to a

total of 60. Therefore, in respect of overall organisation of the study, the use of a professional transcriber was beneficial for purposes of time and convenience.

#### **4.8.4 Longitudinal Study**

The term 'longitudinal' refers to a variety of studies that are conducted over a period of time (Cohen et al. 2007: 211). A key aspect of my study aims to follow a group of dyslexic nursing students from student to registered nurse over a period of approximately 12 months (six months pre-registration and six months post registration), thus exploring a period of transition over an extended period. There are a number of types of longitudinal studies, cross-sectional or trend studies for example. However, the type of longitudinal study that investigates the same participants, rather than different participants, over an extended period is described as a 'cohort study.'

A cohort study is well suited to studies where the development of individuals is being observed. Bryman (2008) described a cohort as constructed of people who share a certain characteristic, which is a feature of the sample of dyslexic nursing students in this study. Cohen et al. (2007) described the benefits of cohort studies in terms of observation of human growth and development. The study does not aim to explore specifically human growth or development; rather, it aims to explore professional growth and development, specifically the experiences of the nursing students during their final six months on an undergraduate nursing programme and their later transition to registered nurses. Hence, the cohort study has the advantage of following the unique development of this recruited sample.

The study additionally aims to explore past experiences of the final year nursing students in terms of what might have shaped and influenced how they cope with their

dyslexia now as well as their use of strategies to overcome their difficulties. This approach adds a retrospective aspect to this longitudinal study. It is argued by Cohen et al. (2007) that participants will look at past events through the lens of hindsight and subsequent events rather than what those events meant at the time. However, any past experience is significant. Certainly, the experiences sought by the researcher will be always second hand, thus a reliance upon the participant's interpretation and meaning of those experiences is what is important, rather than when they actually occurred.

The true value of longitudinal studies is the ability to not only track the development of participants over time, but also the building of a professional relationship with the participants over the duration of the study. This has an advantage of the participants hopefully being more willing to be more open in their responses. Additionally, given the sensitivity of the subject, with many dyslexic nursing students being unwilling to disclose their dyslexia as highlighted in previous studies, a longitudinal study over an extended period hopefully allows the students to become more confident and open in talking about their own personal experiences.

A key disadvantage of longitudinal studies is sample attrition. The reason for this is that as longitudinal studies take place over an extended period, there will always be a risk that participants will drop out during this period for any number of reasons. This potentially can skew the overall findings of such a study and affect the study's trustworthiness and authenticity. However, as previously discussed, the aim of my study from a population and sample perspective is not to represent a specific population of dyslexic nurses or generalise from the findings, rather the aim is to

explore a unique group of dyslexic nurses and a group of mentors/preceptors' perceptions through a case study design. Thomas (2011: 212) stated that the value of generalisability in social science will always be limited by the sheer variability of social life and human agency in all of its predictability.

Therefore, the question arises is the issue of sample size as well as attrition such a serious concern in this longitudinal case study? Certainly, if all of the study sample 'dropped out' this would be a very serious concern; however, choosing a sample of six nursing students from two sites and the same number of mentors, nurse tutors and preceptors allowed for some potential attrition, without affecting the overall theoretical generalisability of the study.

#### **4.8.5 Triangulation and Case Study**

Triangulation is defined as 'involving the practice of viewing things from more than one perspective and can mean the use of different methods, different sources of data or even different researchers within a study' (Denscombe 2010: 346). Case studies sit comfortably with the principles of triangulation through use of wide varieties of data collection methods and analysis tools. Thomas (2011) described triangulation as an essential prerequisite for using a case study approach in terms of looking into a topic or subject area from different angles and vantage points. Cohen et al. (2007) stated that triangular techniques in the social sciences attempt to map out, or explain more fully the richness and complexity of human behaviour by studying it from more than one standpoint. It is this richness and complexity that is a key element of this study in terms of exploring the individual experiences of nurses with dyslexia, as well as those that support them in clinical practice and at university.

Denzin (1978) distinguished four different forms of triangulation, namely triangulation of data, triangulation of theories, investigator triangulation and triangulation 'within method'. However, in examining these different forms, triangulation of data, at first glance appeared to match my approach to my methods of gathering data from my participants. Flick et al. (2004) described triangulation of data as combining data drawn from different sources and at different times, in different places or from different people. In further analysis of my methods, my approach does involve gathering data from different people, namely nursing students, mentors, nurse tutors and preceptors and at different times in relation to the longitudinal element of my study. Additionally, a further element of data collection involves the analysis of NMC documents. Furthermore, the method of semi-structured interviewing involves iterative interviewing, a specific method of interviewing where the researcher interviews the participant on two separate occasions to expand on points and areas of interest in the first interview. An iterative approach is one where the content of the discussion, stimulus or sometimes even the methodology is adapted over the course of the research programme. Learning from initial research sessions is used to influence the inputs for subsequent interviews (AQR 2013).

It can be argued whether the approach of semi-structured interviews to collect data for the participants for this study is true triangulation. Firstly, only one singular method is used to collect data from the participants, there are no plans to additionally observe the participants in their workplace. In addition, the separate analysis of NMC documents is not directly related to the participants; rather, it is a further consideration of elements that influence disability policy in nursing and nurse education. The approach refers more to the 'think small, drill deep' philosophy described by Thomas

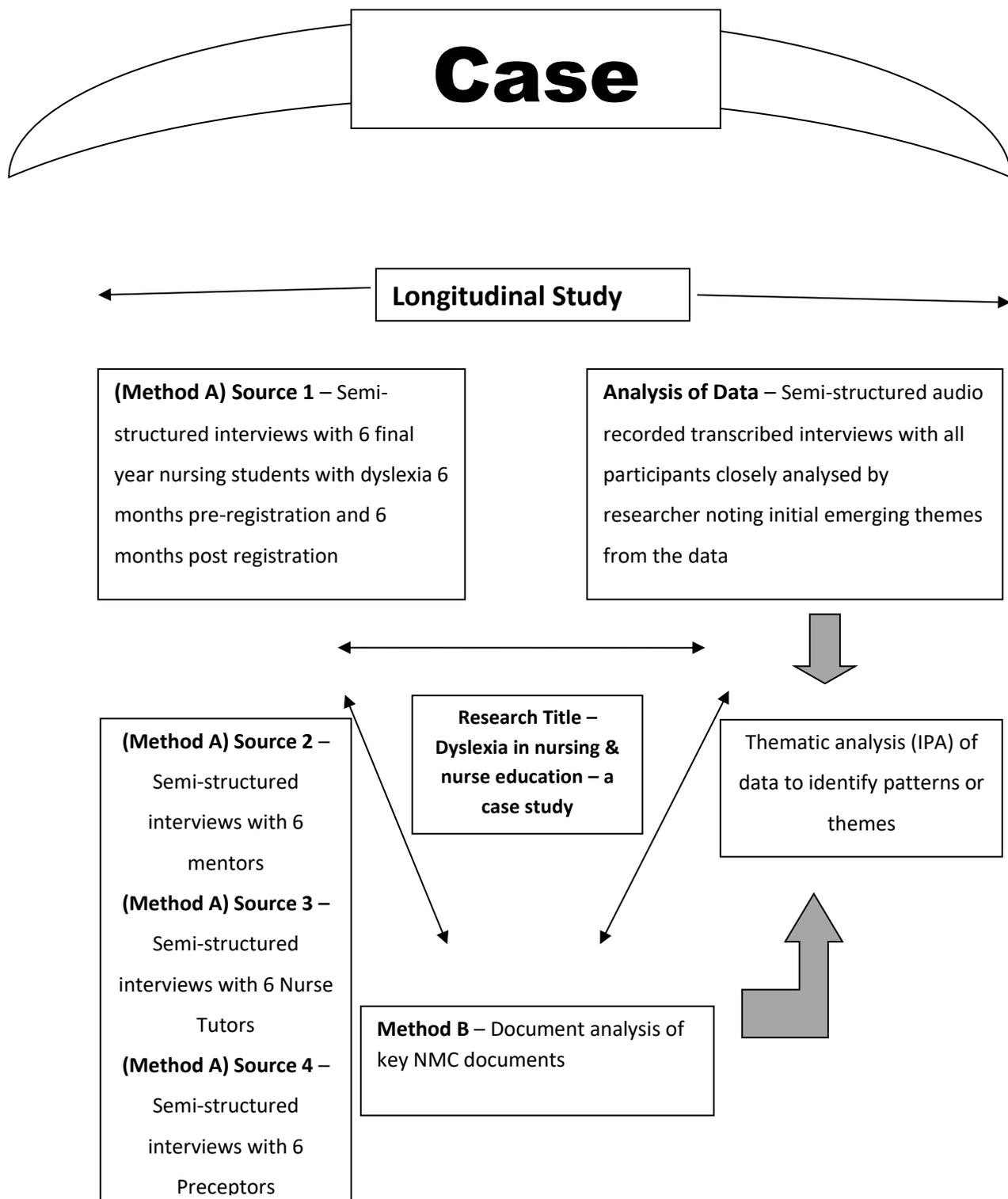
(2011) in relation to the case study method. It has previously been highlighted that of the four different forms of triangulation described by Denzin(1978), triangulation of data is most relevant in this study in relation to collecting data from different people at different times.

Thomas (2009) added a further category to Denzin's types or forms of triangulation, specifically, 'design frame triangulation' suggesting if you used both a case study and a longitudinal study together in the same piece of research, this would be triangulation, which my study employs.

More recently Denzin (1989) and Denzin and Lincoln (1994) re-evaluated triangulation following criticisms from some who argued that triangulation as multiple research methods should be employed to gain a 'total picture' of a phenomenon (Silverman 1985). Additionally, Bloor (1997) commented that triangulation paid too little attention to the fact that every different method constitutes the issue it seeks to investigate in a specific way. Denzin (1989) and Denzin and Lincoln (1994) now accept triangulation as a strategy leading to a deeper understanding of the topic under investigation and thus a step to greater knowledge and less towards validity and objectivity of interpretation. In respect of this and in relation to the 'drill deep' philosophy of the case study method, a deeper understanding is what is being sought in this study. Additionally, the added category of triangulation by Thomas (2009) where a case study and a longitudinal study in the same piece of research constitute a triangulation design, adds some justification to my study adopting a form of triangulation. The emphasis of my study is also upon comparing and integrating differing perspectives from different

participants, which is a feature of the detailed in-depth focus of case study; therefore, from these perspectives, my study does possess some features of triangulation design.

The methods and tools of data collection and analysis outlined in the design frame' (section 4.8) are reflected in a diagrammatic representation in Figure 4.3. This diagram demonstrates how differing methods within the research design are collectively employed to create a fuller rounded picture of what might be occurring within the context of this study.



**Figure 4.3 – Diagrammatic representation of the methods and analysis used within this longitudinal case study design**

## 4.9 Chapter Summary

This chapter has presented an overview of the specific methodology, methods and design for this study: a longitudinal case study design adopting interpretative phenomenological analysis.

The focus of the study, and thus its unit of analysis, is dyslexia in nursing and nurse education. It aims to explore the experiences, perceptions and understanding of dyslexia within nursing and nurse education, through the voices of six nursing students with dyslexia in their final six months of their undergraduate nursing course and in their first six months as registered nurses. Iterative semi-structured interviews are adopted to gather qualitative data, thus each participant is interviewed on two occasions at two distinct points. Additionally, six mentors, six preceptors and six nurse tutors who have a professional connection to the nursing students/registered nurses in this study are interviewed on two occasions, again using an iterative semi-structured interview technique.

The contents of two specific NMC documents are also analysed, with specific reference to dyslexia, but broadly to disability in nursing. All the subsequent data from the interviews is analysed adopting IPA to identify themes or patterns arising from this data. Additionally, the contents of the two NMC documents that directly relate to guidance and regulations on disability in nursing are analysed using a grounded theory document analysis approach to identify themes or patterns that arise from the contents of the text.

Collectively, from this comprehensive variety of differing data sources, the study aims to gather a holistic depiction of dyslexia in nursing and nurse education particular to

the two chosen HEI sites and associated clinical areas. However, in adopting a case study approach, the findings from this study will not be generalisable to similar nursing and nurse education institutions either in the UK or globally; rather, the aim is to provide an insight into the subject of dyslexia in nursing and nurse education.

## **CHAPTER 5: Analysis and Findings of Research Data – Nursing Students/Registered Nurses**

### **5.1 Introduction**

This chapter begins the process of the analysis of the research data. This chapter will specifically focus on the nursing students categorised as case 1 followed by the registered nurses categorised as case 2. Additionally, a summary of findings for each theme will also be included. As outlined in the methodology and design, Chapter 4, the chosen approach to the analysis of the data is interpretative phenomenological analysis (IPA). This approach involves a number of specific stages. IPA, developed by Smith et al. (2009), allows a rigorous and systematic exploration of ideographic subjective experiences (Biggerstaff and Thompson 2008). Smith et al. (2009) outlined clearly the process and stages of the IPA process, but state there is not a prescription of a single 'method' and promote what they describe as a 'healthy flexibility to matters of analytic development' (Smith et al. 2009: 79). However, for the purposes of an academically driven research thesis such as this, there is a prescriptive requirement to demonstrate a rigorous staged process of analysis. In respect of this, this chapter will first briefly outline these specific stages of the analytic process from the initial analysis of the recorded transcripts through to the separation and cluster of themes from this data.

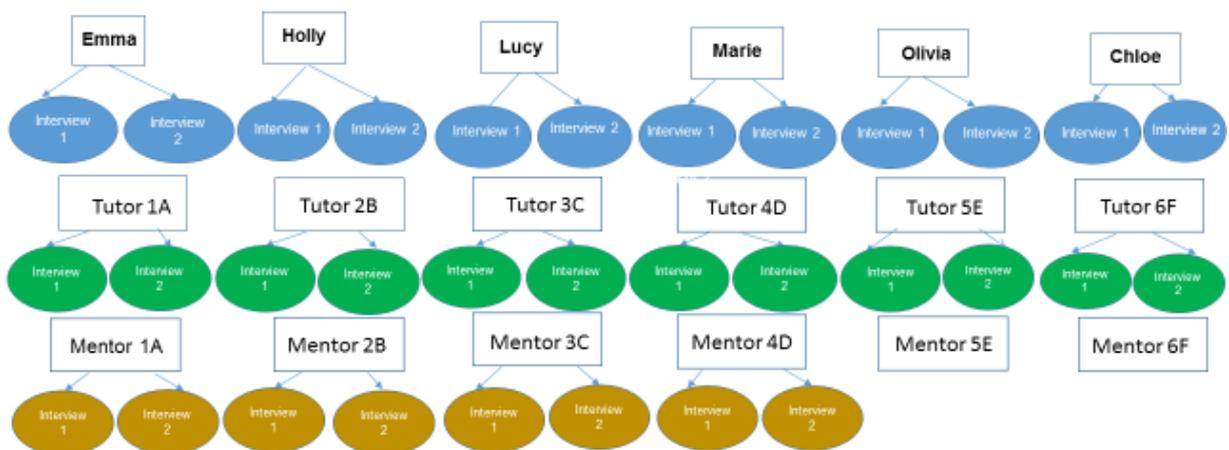
### **5.2 Stages of the IPA Process**

Smith et al. (2009) described six specific stages to the analytic process of IPA as follows:

1. Reading and re-reading
2. Initial noting
3. Developing emergent themes
4. Searching for connections across emergent themes
5. Moving to the next case
6. Looking for patterns across cases

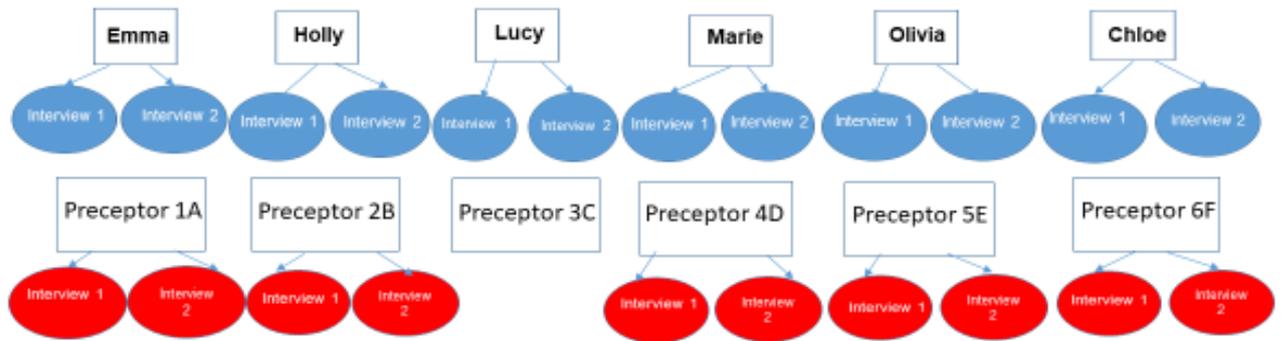
As outlined in Chapter 4, this study is a longitudinal study, divided into two distinct phases, phases 1 and 2, as detailed in Figures 5.1 and 5.2:

## Record of Interviews – Phase 1



**Figure 5.1 – Record of interviews – phase 1**

## Record of Interviews – Phase 2



**Figure 5.2 – Record of interviews – phase 2**

In Chapter 4 (Methodology and Design), a schedule for the interviews (Figure 4.2) was outlined detailing the different stages of the interviews planned for this study. On completion of the data collection, not all interviews were achieved with every participant. As is noted in Figure 5.2 (phase 1) two mentors (5E & 6F) were not interviewed. Firstly, contact could not be made with mentor participant 5E and mentor 6F did not wish to participate in the study. Additionally, in phase 2 (Figure 5.2) preceptor 3C was not interviewed, as they did not wish to participate in the study. Therefore, on completion of the data collection, 27 of the participants were interviewed, out of the planned 30. There is always potential risk in any research study that it will not fully recruit its expected number of participants; however, an expected ‘dropout’ of participants should be accounted for. In this study, 90% of the planned number

participated with 10% who did not, which is an acceptable 'dropout' figure for such a study.

### **5.3 Case 1 – Nursing Students**

As outlined in the introduction, this chapter will specifically focus on case 1 (nursing students) and case 2 (registered nurses); therefore, this section will first focus upon the nursing students categorised as case 1.

#### **5.3.1 Step 1 of IPA – Reading and Re-reading**

Smith et al. (2009) described step 1 as immersing oneself in the original data. This requires time to listen to the audio recordings of the interviews as well as reading and re-reading through the transcripts. Smith et al. (2009) described this first stage as allowing the participant to be the focus of analysis.

This stage is difficult to appraise in terms of the physical evidence you have read, re-read and listened to. However, at the early stage of the process I made initial notes of particular parts of the transcript that were of interest, and my initial notes and observations on reading through and listening to the transcripts are summarised in Table 5.1.

These initial thoughts were a reflection of what emerged out of the data from the nursing students as I collectively read and listened to the audio recordings. Overall, dyslexia had not been an overly positive experience for some in terms of their life stories from school through to entering nurse training, However, this experience varied widely from positive feelings of being supported at school and receiving extra lessons to having negative feelings and being unsupported. The word 'embarrassment' or 'embarrassed' appeared with increasing frequency throughout these transcripts and

this became more apparent as I read them. It also became apparent that the students were fearful of what others thought of them because of their dyslexia.

**Table 5.1 – Initial notes and observations from nursing student transcripts**

1. A fear of disclosure of dyslexia by some
2. Embarrassment by many of being dyslexic
3. Negative school experiences for many
4. Thought they could not become a nurse because of their dyslexia
5. Nurses are clever, I'm not
6. Fear of what others are thinking of me, think I'm stupid
7. Caution and hypervigilance administering drugs
8. Difficulty with aspects of documentation – spelling, thinking of what to write, get my thoughts from head to paper
9. Some more difficulties lesser or greater in others – variability of dyslexia
10. Impact of dyslexia upon them as individuals
11. Difference between university and clinical practice

### **5.3.2 Step 2 of IPA – Initial Noting**

Step 2 of IPA, the initial level of analysis, is described by Smith et al. (2009) as the most detailed and time consuming. This step involves noting and commenting on the interview transcript. Smith et al. (2009) broke down this initial analytic process into three distinct elements as follows:

1. Descriptive comments focused on describing the content of what the participant has said, subject of talk within the transcript
2. Linguistic comments focused upon exploring the specific use of language by the participant
3. Conceptual comments focused on engaging at a more interrogative and conceptual level (Smith et al. 2009: 84)

These three specific elements of step 2 of IPA were adopted throughout the analysis of the transcripts, an example of which is placed for each participant within Chapters 5

and 6, with a selective sample of analysed transcripts located in Appendices 1 to 5.

Each of these elements are identified by a specific style of text described as follows:

1. Descriptive comments – **normal text**
2. Linguistic comments – *italic text*
3. Conceptual comments – underlined text

These initial thoughts perhaps sub-consciously began to develop into early themes.

Following the systematic process of IPA the emergence of themes does not appear until step 3 (developing emergent themes). The data in this study, outlined in Figures 5.1 and 5.2 (Record of Interviews – Phases 1 & 2), comprises 54 transcripts. Smith et al. (2009) commented on the analysis of large amounts of data and remark that themes can be identified at case level. From this perspective, the initial noting on case 1, namely nursing students, is divided into themes A, B, C etc. at this stage according to what emerged from step 1, as well as focusing upon research question 1a as follows:

**RQ 1a. What do nursing students with dyslexia think influences and shapes their professional and educational experience in clinical practice?**

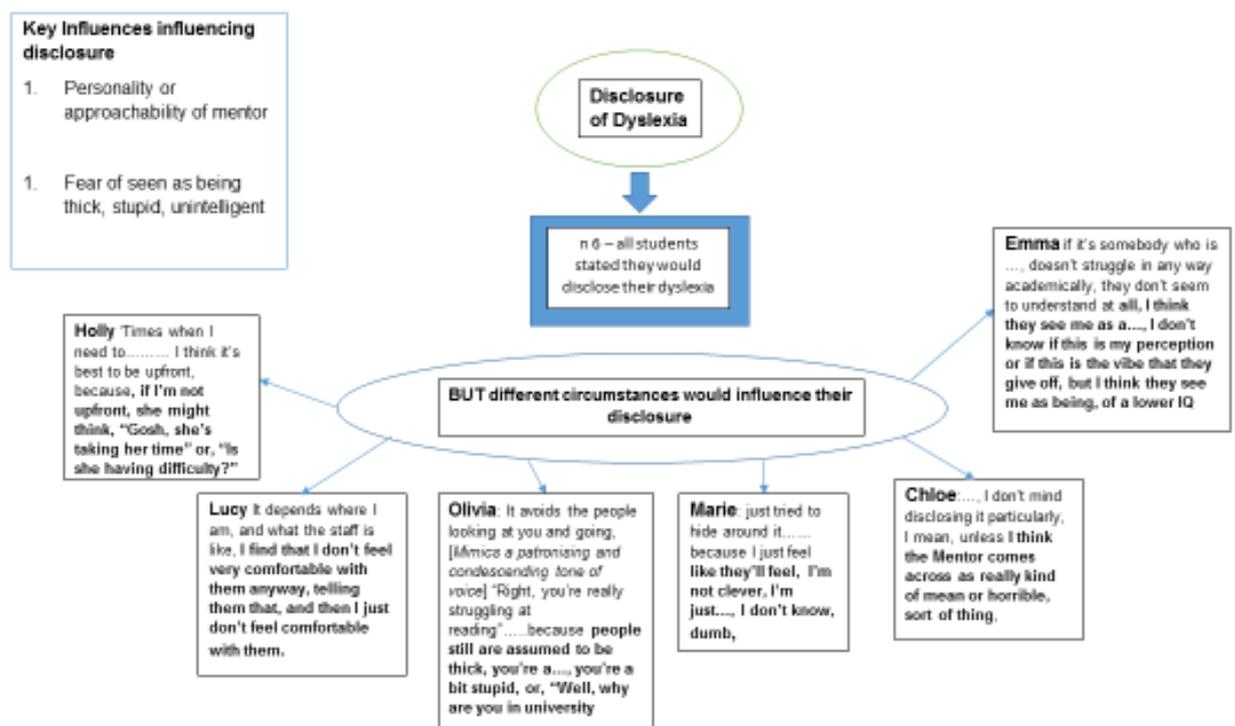
Each transcription from each nursing student was analysed adopting the three elements of IPA transcription analysis described by Smith et al. (2009). Table 5.2 is one example of this transcription analysis for a nursing student participant. A selection of analysed nursing student transcriptions is located in Appendix 1. Each theme that emerged from the interview data is presented in this Chapter in a visual diagrammatic format with a narrative summary of each theme.

**Table 5.2 – Interview with Emma – disclosure (nursing student)**

<p><b><u>Emma Interview 1 Emma pp. 9/10</u></b></p> <p>BG After disclosing your dyslexia, have you ever received a strong reaction ...whether that's positive or negative, either in practice or here at university, or anywhere else for that matter?</p> <p><b>Emma:</b> I've had people when I've disclosed it say, 'Do you know? I think that I've got a bit of that'. When I have explained, you know, they have said 'That's quite common', or if they know..., somebody knows somebody in their family who have got it, they totally understand, but <b>if it's somebody who is..., doesn't struggle in any way academically, they don't seem to understand at all, I think they see me as a..., I don't know if this is my perception or if this is the vibe that they give off, but I think they see me as being of a lower IQ</b>, I don't think they realise that I have still got high intelligence, it's just the way that I process information and give my information, it..., it's just different.</p> <p><b>Emma</b> .....and yeah, <b>I do think they see me as..., [pauses], yeah, as daft [Chuckles]</b>.</p> <p>BG Have you ever received an outwardly negative reaction?</p> <p><b>Emma</b> [Pauses] <b>no, I don't think I have, nobody has been obvious, [Long Pause], no.</b></p>	<p><i>Categorises reactions to disclosure between those who suspect they have elements of a dyslexic trait or family members who have it and then identifies those who don't struggle academically and don't understand it</i></p> <p><u>Perception of linking dyslexia and academia or intelligence in what others may consider it as</u></p> <p>Discussion of a perception from those who don't understand give off a vibe of her having a lower IQ</p> <p><u>Note, this hasn't being said to her, rather this is her perception of what others think of her, almost having a perceived inner feeling of what someone might be thinking of her because of her dyslexia, in this case negatively</u></p> <p><i>Identifies herself as having high intelligence noting a different way she processes information – citing dyslexia as simply just being 'different'</i> <u>Use of the word 'daft', again a self-perception or inward thought of how others see her</u></p> <p>Clarification that she cannot recall ever receiving an outwardly negative reaction to her dyslexia</p>	<p>Negative self-perception from others of dyslexia</p>
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### 5.3.2.1 Summary of Findings – Disclosure of Dyslexia

All the students (n6) stated for the most part they would disclose their dyslexia. However, this disclosure was dependent upon differing circumstances outlined in Figure 5.3:



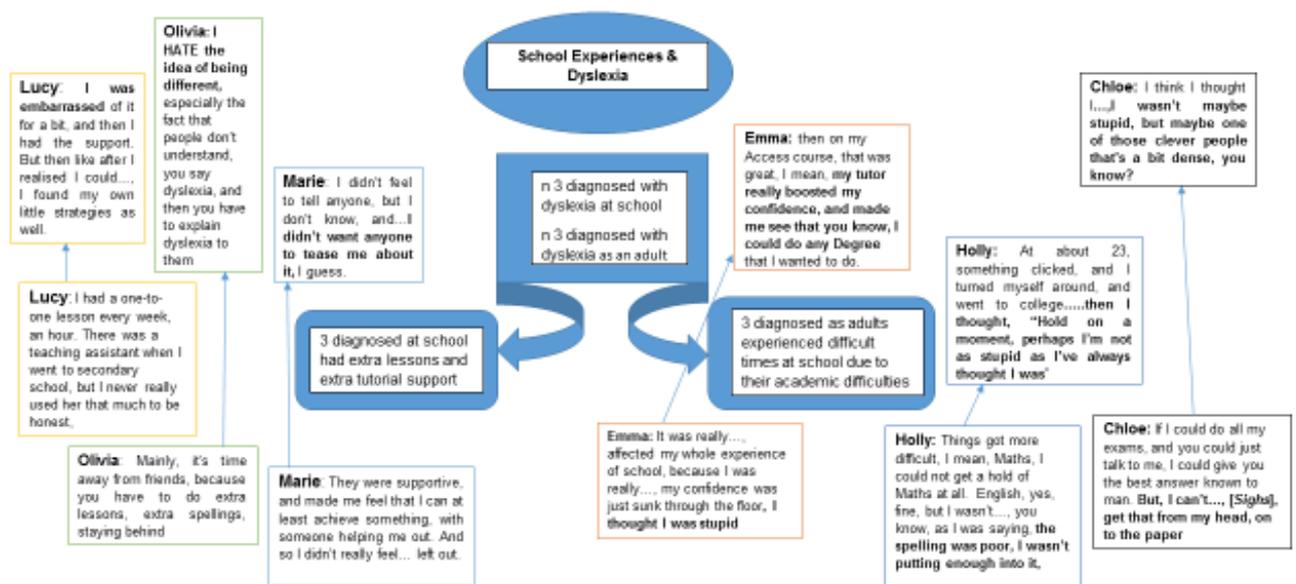
**Figure 5.3 – Summary of key influences and statements on disclosure of dyslexia**

Holly's reason for disclosure was fearing being seen by others as having a difficulty or taking her time, and she wanted to account for her difficulties because of her dyslexia. However, Emma, Olivia and Marie were conscious of what others might think of them in terms of being perceived as having a low IQ or 'not clever' or 'thick' and so were fearful of disclosure for this reason. Chloe and Lucy both cited the personality of the

mentor affected their dyslexia disclosure. Lucy stating if she did not feel comfortable with them or in Chloe’s case, if they came across as ‘mean or horrible’.

### 5.3.2.2 Summary of Findings – School Experiences

The school experiences of the students varied significantly between the students, as summarised in Figure 5.4:



**Figure 5.4 – Summary of key statements and impact from school experiences relating to dyslexia**

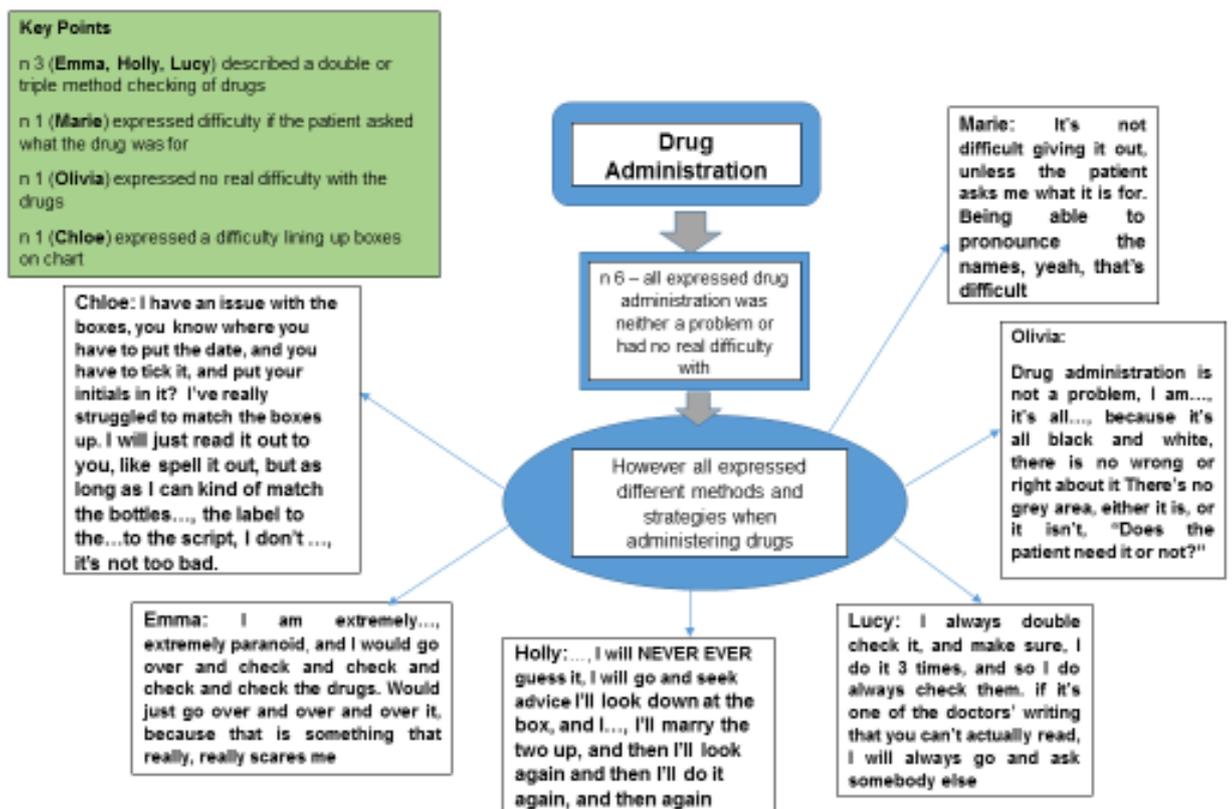
Lucy, Olivia and Marie received their dyslexia diagnosis at school and this generally appeared to result in a more positive experience in terms of receiving early support for their dyslexia. Lucy, despite feeling a little embarrassed initially, commented on her own little strategies developed during this period; Marie felt she could really achieve something. However, in contrast, Olivia commented that she hated the idea of being

different and hated the time away from friends doing extra spellings and staying behind, and having to explain her dyslexia to others.

Emma, Holly and Chloe did not receive their dyslexia diagnosis until adulthood. Emma expressed her anger and frustration that her dyslexia was not picked up at school, and thought she was stupid. Holly described her great difficulty with maths and poor spelling whilst at school. Chloe commented that she did not think she was stupid, but one of those clever people who was a bit dense. She also commented that she could not get information from her head to the paper, but could give an impressive verbal reply to an answer. These findings begin to reveal some differing contrasts between the experiences of those students who received a dyslexia diagnosis as children and those who received their diagnosis as adults.

#### *5.3.2.3 Summary of Findings for Drug Administration*

All the students, for the most part, describe a distinct checking method for drug administration as illustrated in Figure 5.5 below:



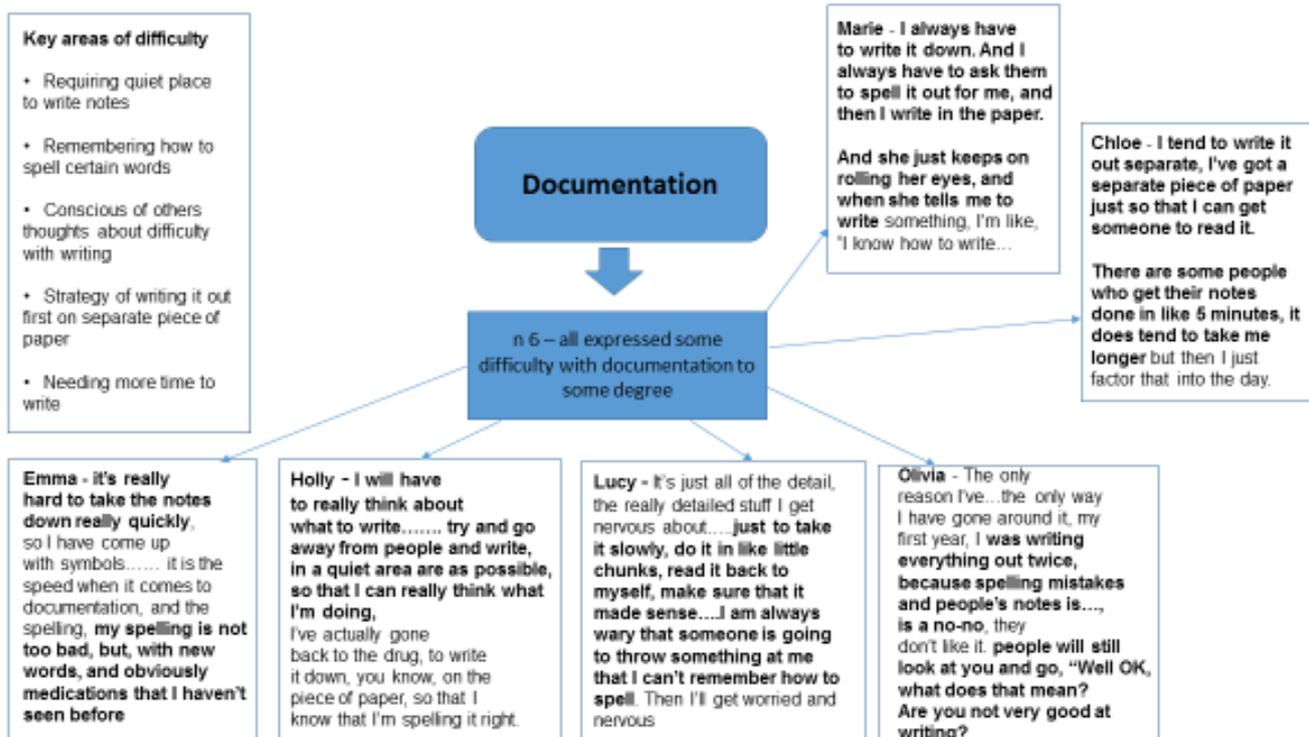
**Figure 5.5 – Summary of Key Points and statements regarding drug administration**

Chloe, Holly, Emma and Lucy all described a collective double or triple checking method to ensure they avoid errors in administering drugs. Marie commented that she checks at least once when administering drugs and uses a strategy of writing down drugs she does not know. Chloe described a particular difficulty in lining up boxes across a chart.

#### 5.3.2.4 Summary of Findings for Documentation

The students' described various difficulties and fears surrounding documentation (see Figure 5.6 below). Emma described it as hard to take notes down quickly and has difficulty with writing new words she has not seen before. Holly commented that she

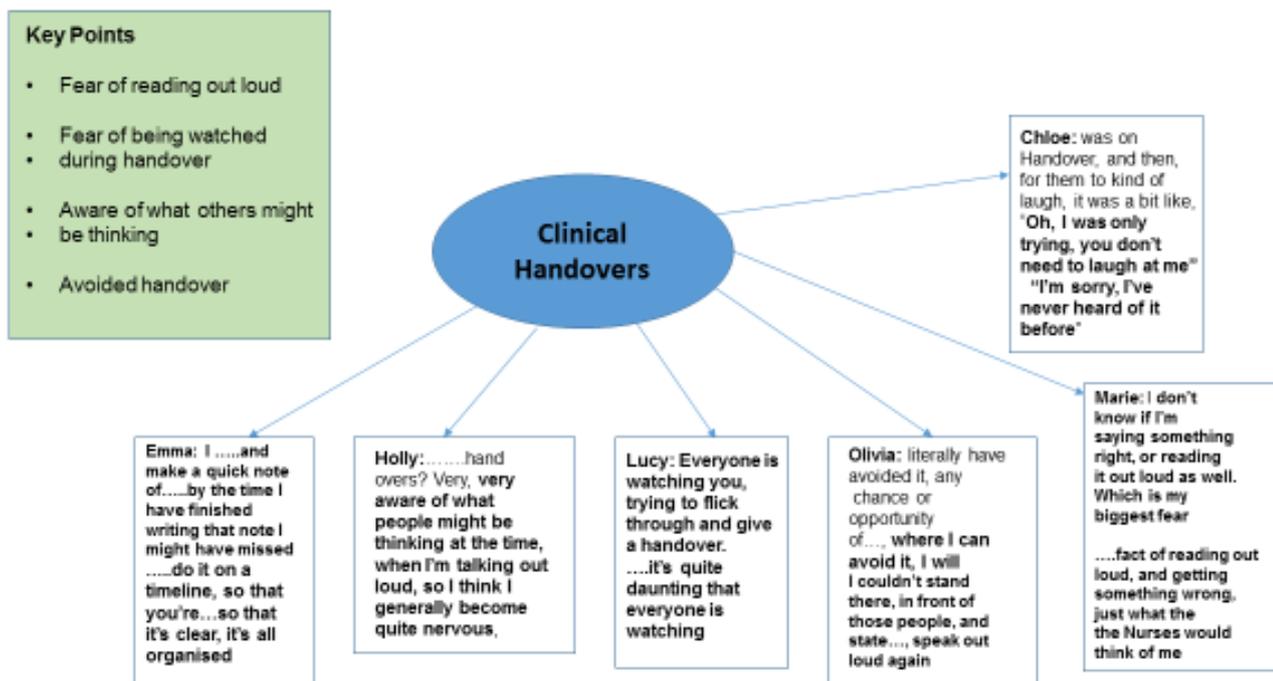
really has to think about what to write and finds a quiet area to write her notes. Lucy described how she has to take it slowly and do her documentation in little chunks; however, she expressed fears that she might be challenged to write a word she does not know how to spell. Olivia described a strategy of writing her documentation out twice to avoid spelling mistakes and additionally to try to prevent questioning from others over her writing. Chloe used a similar strategy to Olivia in writing her documentation out first on a separate piece of paper, so someone else can check this first. Marie also used a similar strategy of writing it down first to get others to check her spelling before writing it all out on the proper documentation. There is evidence of a number of perceptions by the students of fear of others' reactions to their difficulties with documentation. Olivia feared someone picking her up on her spelling mistakes; Lucy feared someone might ask her to write a word she does not know how to spell.



**Figure 5.6 – Summary of key areas of difficulties/experiences with documentation experienced by nursing students with dyslexia**

### 5.3.2.5 Summary of Findings for Clinical Handovers

The students spoke particularly of the fear of speaking aloud during handovers as outlined in Figure 5.7:



**Figure 5.7 – Summary of fears surrounding clinical handover amongst nursing students with dyslexia**

Holly, Lucy, Olivia and Marie spoke specifically of this fear commenting on the experience of others' watching them and what others might be thinking of them. Olivia admitted she has purposely avoided handover as a student, because of the fear of standing in front of people and speaking aloud. Chloe spoke of a particular incident where she was laughed at during a handover, because she was unable to pronounce a word. Similarly, with documentation, there is evidence of a fear amongst the students of what others think of them.

### 5.3.2.6 Summary of Findings for Self-perception of Dyslexia

What became apparent across this theme is that all the students expressed, to a greater or lesser degree, a fear of what others think of them. Emma, Holly, Lucy, Olivia and Chloe described embarrassment of what others might think of them or a perception of others thinking they are thick or not clever enough or cannot do a normal job. Marie spoke of her own self-perception that she could not do nursing because of her dyslexia. Collectively all the students expressed a negative self-perception of dyslexia in terms of what others think of them. There appeared to be no evidence that no one had ever expressed a negative judgment to them about their dyslexia. Rather, these expressed perceptions appeared to be solely their own self-perception. A summary of finding is presented below in Figure 5.8:



Figure 5.8 – Summary of self-perceptions about dyslexia from nursing students with dyslexia

### 5.3.3 Step 3 – Developing Emergent Themes

The next step of IPA involved a closer examination of the data to develop emergent themes. This was undertaken by reading through the data transcription tables and creating a third column in the table and identifying common themes or sub-themes from this data, which were noted in this third column. The initial themes from the initial noting stage are listed in Table 5.3.

**Table 5.3 – Case 1 – six nursing students’ initial themes (phase 1)**

- |                           |
|---------------------------|
| A. Disclosure of dyslexia |
| B. School experiences     |
| C. Drug administration    |
| D. Documentation          |
| E. Clinical handovers     |
| F. Self-perception        |

These themes were put into a diagrammatic format to visualise these collectively with key statements from each participant, which were also used as an aid to identify emergent themes. Two examples of these emergent themes (C and F) are included in Figures 5.9 and 5.10. All emergent themes, A to F, for the nursing student participants are located in Appendix 17.

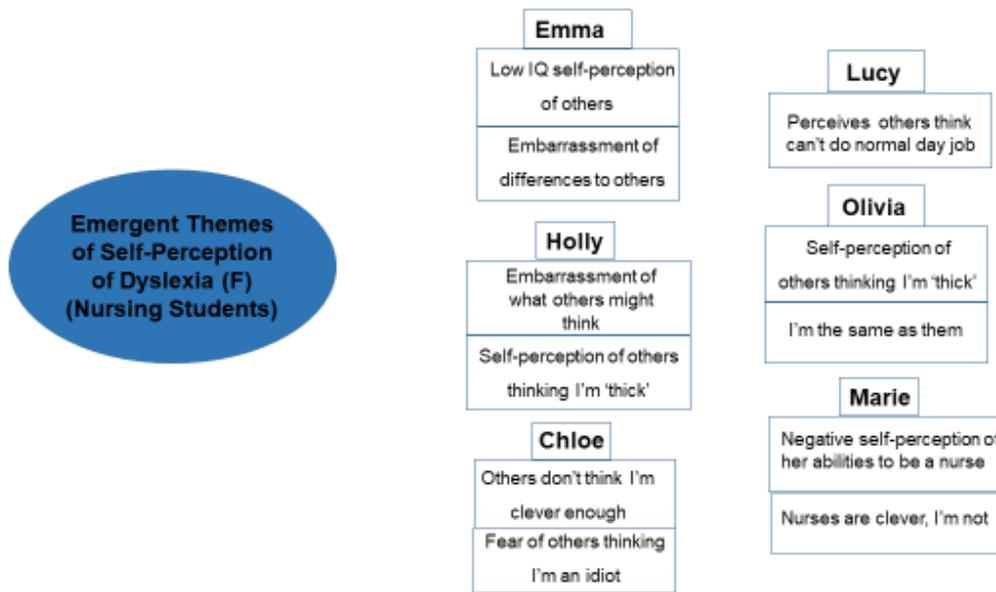


Figure 5.9 – Emergent themes – self-perception of dyslexia (student nurses)

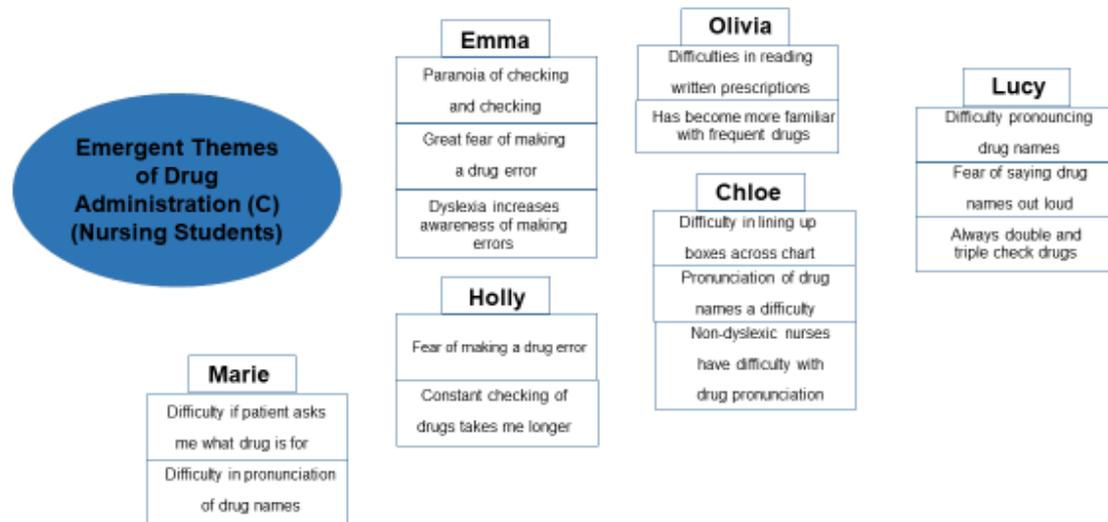


Figure 5.10 – Emergent themes – drug administration (student nurses)

I then began to look across these diagrams to identify commonalities and similarities in these themes, noting the number of participants across the sample who had made similar key statements. This was formulated into a table (Table 5.4) to identify connections across themes.

#### **5.3.4 Step 4 Searching for Connections across Emergent Themes**

The descriptions of these stages in the analytical process progressed this further into step 4, where searching for connections across emergent themes commenced. The following table (Table 5.4) outlines themes that emerged from the data of case 1 of the nursing students:

**Table 5.4 – Emergent themes for case 1 – nursing students**

<p><b>1. <u>Nursing Students – Drug Administration</u></b></p> <ul style="list-style-type: none"> <li>• Fear of making drug errors (n2)</li> <li>• Double and/or triple checking drugs (n3)</li> <li>• Paranoia over checking drugs (n1)</li> <li>• Difficulty with pronunciation of drugs (n2)</li> <li>• Non-dyslexic nurses have difficulty with drug pronunciation (n1)</li> <li>• Difficulty in reading Drs’ writing (n1)</li> </ul>
<p><b>2. <u>Nursing Students – Documentation</u></b></p> <ul style="list-style-type: none"> <li>• Embarrassment/fears of others reading my writing (n3)</li> <li>• Fear of spelling words and others’ reactions (n1)</li> <li>• Use of quiet area (n2)</li> <li>• Writing out first on separate paper before main documentation (n3)</li> <li>• Takes longer to write (n1)</li> </ul>
<p><b>3. <u>Nursing Students – Clinical Handovers</u></b></p> <ul style="list-style-type: none"> <li>• Embarrassment of what others think (n2)</li> <li>• Worry/fear of reading aloud in handovers (n3)</li> <li>• Embarrassment of being laughed at in handover and impact of this (n1)</li> <li>• Difficulty keeping up in handovers (n1)</li> <li>• Purposely avoiding handovers (n1)</li> </ul>
<p><b>4. <u>Nursing Students – Self-perception</u></b></p> <ul style="list-style-type: none"> <li>• Embarrassment of difference from others (n1)</li> <li>• Self-perception of others thinking I’m thick/low IQ (n4)</li> <li>• Others don’t think I’m clever enough (n2)</li> <li>• Perceive others think I can’t do a normal day job (n1)</li> </ul>
<p><b>5. <u>Nursing Students – Disclosure</u></b></p> <ul style="list-style-type: none"> <li>• Personality of mentor affects disclosure (n2)</li> <li>• Negative self-perception from others about dyslexia influences disclosure (n3)</li> <li>• Disclose to prevent negative self-perceptions from others (n1)</li> <li>• Actual dyslexia disclosure not threatening at all (n1)</li> </ul>

#### **6. Nursing Students – School Experiences**

- Anger dyslexia wasn't picked up at school (n1)
- Anger and frustration over negative teacher reaction (n1)
- Frustration over difficulties at school (n1)
- Hated idea of being different (n1)
- Lack of recognition of difficulties in school (n2)
- Fear of reading out loud (n1)
- Extra lessons made me feel less isolated (n1)
- Extra lessons gave a feeling of isolation (n1)
- Diagnosis at early age made no difference (n1)
- Early diagnosis at school meant early support (n1)

What first becomes apparent from this table is that the word embarrassment appears on three separate occasions in documentation (2), clinical handovers (3) and self-perception (4) suggesting that the students felt some stigma about their dyslexia and were conscious of what others might think of them, particularly fearful that others are thinking they are thick or of low IQ. This is also reflected in disclosure (5) where there is evidence that a negative self-perception of others influences disclosure of dyslexia. Such evidence of feelings of stigmatisation might lead us to enquire, what were the sources of this embarrassment or stigma of dyslexia? In respect of this, looking at school experiences (6), there is evidence of both anger and frustration at school difficulties experienced because of dyslexia. Also, that dyslexia was not picked up or that there was a lack of recognition of difficulties at school, particularly amongst those who were identified as dyslexic when adults. At this stage, this is a somewhat tentative

connection between their experiences as nursing students and school. This will be further explored in the discussion chapter, but in identifying such a frequent and common theme, there is value in any research to enquire of the source of this.

There is also evidence of strategies to counteract the difficulties faced by the nursing students because of their dyslexia, such as double or triple checking drugs, use of quiet areas to write up documentation and writing up first on separate paper prior to writing up proper in their nursing notes. This might suggest an acute consciousness of their difficulties because of their dyslexia, and the use of such strategies may not only be to reduce errors and make them safer, but also to perhaps reduce stigmatisation from others. These observations from the data will be discussed in greater depth in the discussion chapter. With reference to the initial identification of themes in case 1 (nursing students), identified in Tale 5.4, this directly links to the first research question of this study, question 1a:

**RQ 1a. What do nursing students with dyslexia think influences and shapes their professional and educational experience in clinical practice?**

Question 1a enquires about specific influences within the nursing student's clinical practice with direct regard to their dyslexia. A number of themes (Table 5.4) had already begun to emerge which began the initial process of answering the question of identifying specific influences that shape their experiences in practice, such as embarrassment and stigma, and strategies to attempt to reduce the likelihood of making errors and thus reducing this stigma and embarrassment surrounding dyslexia.

### **5.3.5 Step 5 – Moving to the Next Case**

Step 5 is detailed in the next section of this chapter where case 2, registered nurses will be considered.

### **5.3.6 Step 6 – Looking for Patterns across Cases**

As this was the first case to be analysed, it was therefore not possible to identify patterns across cases. This step was utilised in the next section (Case 2 – Registered Nurses) to note any patterns across cases. This is of particular importance as case 1 (nursing students) and registered nurses (case 2) are the same participants.

## **5.4 Case 2 – Registered Nurses**

This section now focuses upon case 2, which details the newly registered nurses outlined in Figure 5.2 (phase 2 of the study). It should be noted these are the same nursing students detailed in case 1, who had now become registered nurses, thus incorporating the longitudinal element of this study. Each nurse had been a registered nurse for approximately six months. As in case 1, the same pseudonyms were adopted and each emergent theme was labelled with a code; in case 2, the codes A1, B1, C1 etc. were used.

### **5.4.1 Step 1 – Reading and Re-reading**

As in case 1 (nursing students), the transcripts for case 2 were read, re-read and audio recordings listened to on a number of occasions to obtain a feeling of immersion in the data. I made a number of initial notes and observations during this reading and re-reading stage. These notes and observations are summarised in Table 5.5.

### **Table 5.5 – Initial notes and observations from registered nurse transcripts**

1. Increasing confidence and familiarity in nursing tasks
2. Remain cautious disclosing dyslexia
3. Continued hypervigilance in drug administration
4. Different and challenging now the support from university is no longer there
5. Still anxious over what others might think of them because of their dyslexia
6. Use of Google to check spellings and drug names

#### **5.4.2 Step 2 – Initial Noting**

As detailed in case 1 at the beginning of this chapter, this step involved noting and commenting on the transcript. Smith et al. (2009) broke down this initial analytic process into three distinct elements as follows:

1. Descriptive comments focused on describing the content of what the participant has said, subject of talk within the transcript
2. Linguistic comments focused upon exploring the specific use of language by the participant
3. Conceptual comments focused on engaging at a more interrogative and conceptual level (Smith et al. 2009: 84)

Again, as in case 1, these elements were identified on the analysis tables, as in case 2 by a specific style of text as outlined below:

1. Descriptive comments – **normal text**
2. Linguistic comments – *italic text*
3. Conceptual comments – underlined text

Examples of this analysis on the data transcriptions for case 2 – Registered Nurses are evident in Appendix 2.

Following on from step 1, and as in case 1, initial themes were focused upon, with emphasis now upon research question 1b as follows:

**RQ 1b. How might these influences and experiences change/be changed as they adapt and learn to work as a registered nurse with dyslexia?**

Table 5.6 is one example of an analysed transcription of one of the registered nurses. Similarly, as with the nursing students' data, each theme from the interview transcription data is presented in this chapter in diagrammatic format with a narrative summary of each theme.

**Table 5.6 – Interview with Emma – changes since becoming a registered nurse**

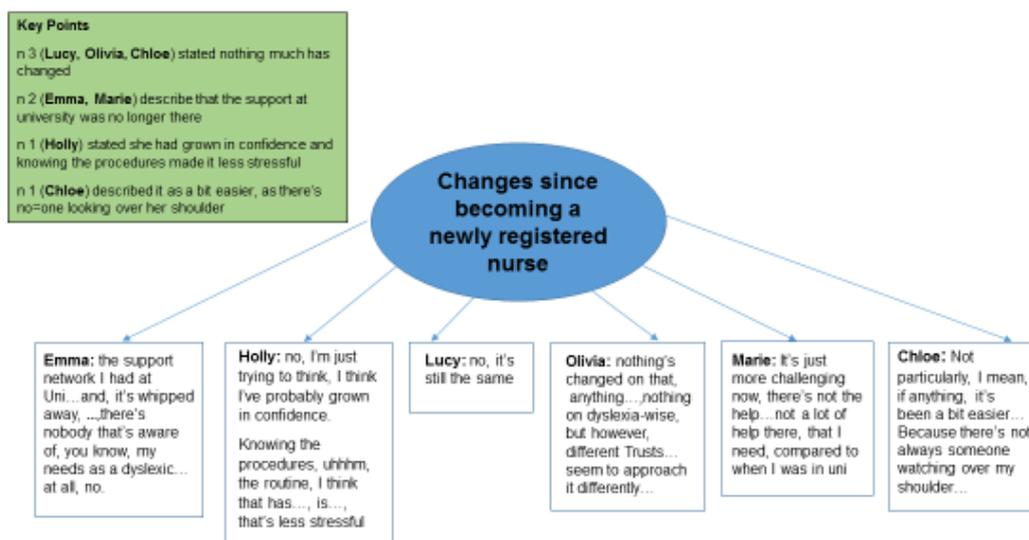
<p><i><u>Interview 1, Emma, p.1.2</u></i></p> <p><i>BG To start off with, since you've become a registered nurse, do you feel anything has changed, or is anything different in relation to your dyslexia?</i></p> <p><b>Emma:</b> <i>[Pauses]</i> I think it's very much down to me...I find that..., <b>that the support network I had at uni...and, it's uhhhm, whipped away,</b> <i>[Chuckles].</i></p> <p>BG Yeah</p> <p><b>Emma:</b> I have..., I do have a person I can turn to, but in respect of dyslexia, it's I can turn to her for other things, but... but, there's not...,</p>	<p><i>The term 'whipped away' very significant about the sudden loss of support that she once had as a student, describes a sudden disappearance of something that clearly had an impact</i></p>	<p>University support no longer there</p>
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<p><b>there's nobody that's aware of, you know, my needs as a dyslexic...at all, no.</b></p> <p>BG Not at all?</p> <p><b>Emma:</b> The paperwork has just changed at the minute...and we <b>just have to read and read and read and read, until I understand it, well I..., I just..., I just..., if someone could just show me... talk me through it once, that's all I'd need, and I'd know it...</b></p>	<p>Describes a lack of anyone that can really understand her needs as a dyslexic</p> <p>Gives an example where there is nobody around to support her in terms of new paperwork</p> <p><u>Almost a feeling of isolation here that she feels very much alone</u></p>	<p>Nobody understands my needs</p> <p>Feeling of isolation</p>
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#### *5.4.2.1 Summary of Findings for Changes since Becoming a Registered Nurse*

In identifying specific changes that have occurred amongst the nurses since they became registered nurses, this tentatively begins to answer research question 1b, which asks what has changed since becoming a registered nurse. Lucy, Olivia and Chloe, commented that nothing has really changed. Holly described how she has grown in confidence and Marie commented that it is now more challenging. However, Emma described how the support network she had at university has been 'whipped

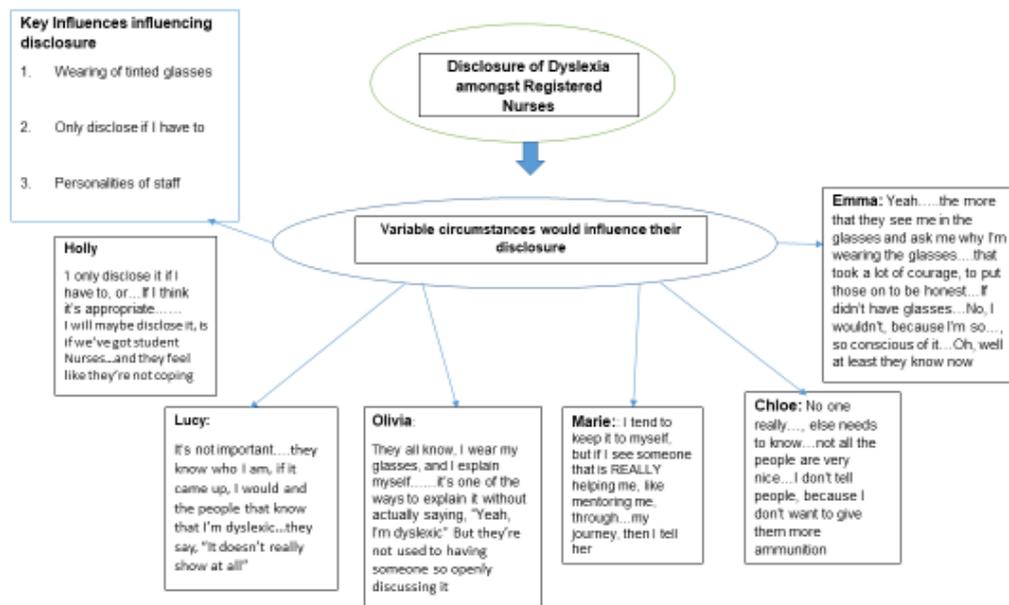
away' and commented there is no one that knows her needs as a dyslexic (Figure 5.11):



**Figure 5.11 – Summary of dyslexic registered nurse comments on changes since becoming a newly registered nurse**

#### 5.4.2.2 Summary of Findings – Disclosure of Dyslexia (RN)

There remained amongst the nurses a reluctance to disclose their dyslexia as illustrated in Figure 5.12 below:



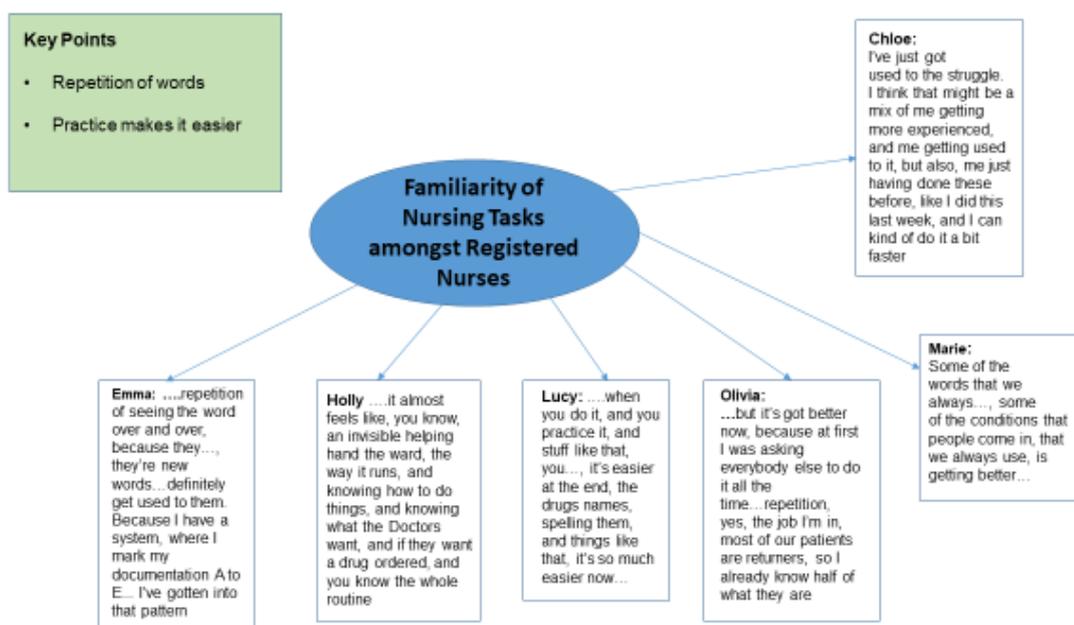
**Figure 5.12 – Summary of dyslexic registered nurse comments on disclosing dyslexia as a newly registered nurse**

Some could see the justification for disclosing; Holly commented it was appropriate to disclose if she was working with someone who works fast as she did not want to be seen as useless, but otherwise would only disclose if appropriate. Emma described how because of the coloured glasses she wore, she had to disclose, as the glasses were a visible indication of her dyslexia. However, she commented how she did not want to be seen as weak and the disclosure was difficult for her. Olivia, similarly, because of her coloured glasses, stated she had to disclose. However, she commented if she did not have the glasses she would not disclose at all, but added she discloses sometimes if she cannot spell a word. Lucy, in contrast was more comfortable with disclosing her dyslexia stating, ‘they know who I am’ and with reference to her dyslexia, ‘I’m open to it, doesn’t bother me’. This suggests a more accepting attitude to her dyslexia not evident amongst the others. Marie described how

if the mentor was helpful, she would disclose, suggesting the personality of the mentor was an important factor in disclosing, but also stated she did not want to be treated differently. Chloe commented that unless there is a problem, she does not bring it up and no one needs to know. This evidence suggests that disclosure of dyslexia remains an issue for many of the nurses and suggests an existing stigma around disclosure following their registration as nurses.

#### 5.4.2.3 Summary of Findings – Registered Nurses, Familiarity of Nursing Tasks

This theme emerged during questioning about changes since becoming a registered nurse (see Figure 5.13).



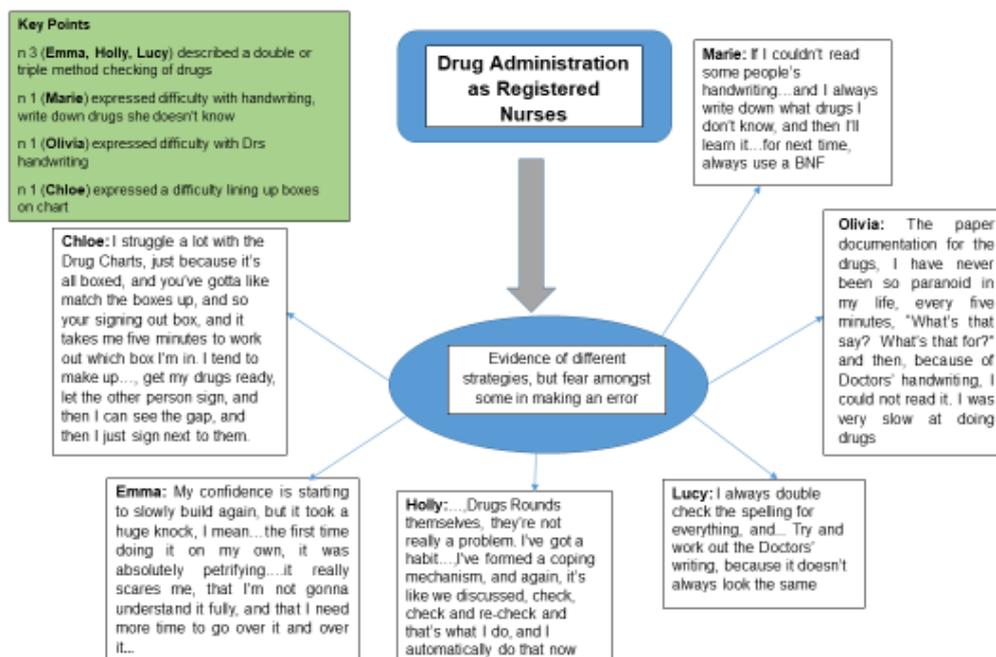
**Figure 5.13 – Summary of dyslexic registered nurse comments on familiarity of nursing tasks**

All the nurses commented, having spent a number of months as registered nurses, that they were becoming more familiar with nursing tasks. Emma commented that

seeing a word 'over and over again' resulted in her getting used to familiar words and the system of marking her documentation A to E referring to an clinical assessment abbreviation system (airway, breathing, circulation etc.). Holly commented on how she began to get used to how the ward worked, getting to know the routine commenting that it 'feels like an invisible hand'. Lucy described how the drug names were much easier now, as she became more familiar practising it, referring to drug names. Olivia commented that a structured routine and repetition helped particularly with returning patients and getting to know their conditions. Marie similarly described how she began to get to know more of the patients' conditions as she became more familiar with them. Chloe described how the 'struggle' was getting easier and that things were getting easier, which she felt was probably due to a mixture of becoming more experienced doing things more frequently and as a result has become faster. This evidence described suggests a familiarity with nursing tasks resulting in these tasks becoming easier to deal with.

#### *5.4.2.4 Summary of Findings – Registered Nurses – Drug Administration*

It was evident that the strategy of continued double and triple checking of drugs as nursing students had remained as registered nurses. The findings are outlined in Figure 5.14:



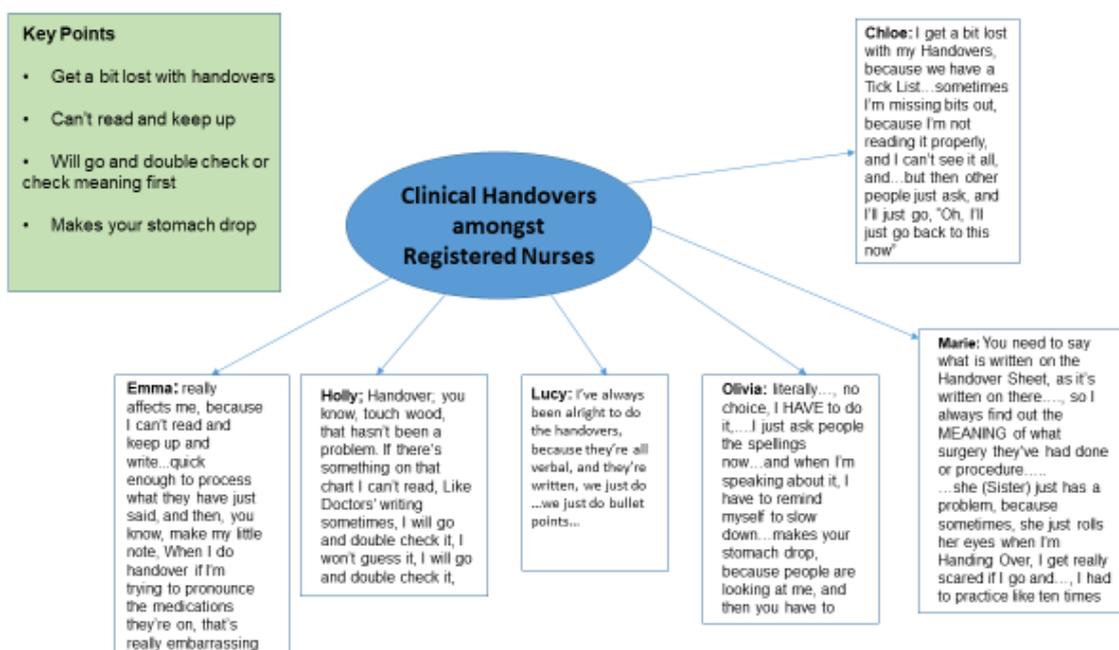
**Figure 5.14 – Summary of dyslexic registered nurse comments on drug administration**

Emma, Holly, Olivia and Lucy all stated they continue to double or triple check the drugs before administering them. Chloe commented that she still has difficulty following the lines and boxes across the drug chart. Marie commented that she checks the drugs at least once and additionally writes down drugs she does not know to aid her familiarity with them. Emma and Holly additionally commented that non-dyslexic nurses would also use the same strategy of double or triple checking; therefore, the question is raised, are there any differences between a nurse with dyslexia and a non-dyslexic nurse in the action of checking drugs?

#### 5.4.2.5 Summary of Findings – Registered Nurses, Clinical Handovers

With regard to clinical handovers, a number of the nurses still spoke of some nervousness when handing over. Emma spoke of the difficulty of keeping up when

listening or receiving handovers, but when giving handovers commented on difficulty in pronouncing drug names, and how embarrassed she felt. She additionally commented of her fear of handing over an entire ward, which she doesn't currently do as she only hands over her own bay of patients. Holly described that she now felt more confident handing over patients. She also commented that there always is a slight element of embarrassment, particularly around difficulty with pronunciation of drug names, but she will double check these first. In contrast, Lucy comments she had always been 'alright' with handovers as they are all verbal in style and uses bullet points to recall major points. Olivia admitted she avoided handover as a student because of her fear of speaking aloud in front of others. She comments that now, she has no choice. She recalled how nervous she was when she first did a handover and it still makes her 'stomach drop' because others are looking at her, but also has to remind herself to slow down. Marie describes how she dreads handovers, particularly over the pronunciation of words and will practice up to ten times before she does handover and check the meaning of surgical procedures first. Marie also commented on a sister who 'just rolls her eyes' when she hands over. Chloe described how she can miss bits out during a handover, but can go back to things if she reminded, but states, 'I don't think anyone notices'. These findings are illustrated in Figure 5.15 below:



**Figure 5.15 – Summary of dyslexic registered nurse comments on clinical handover**

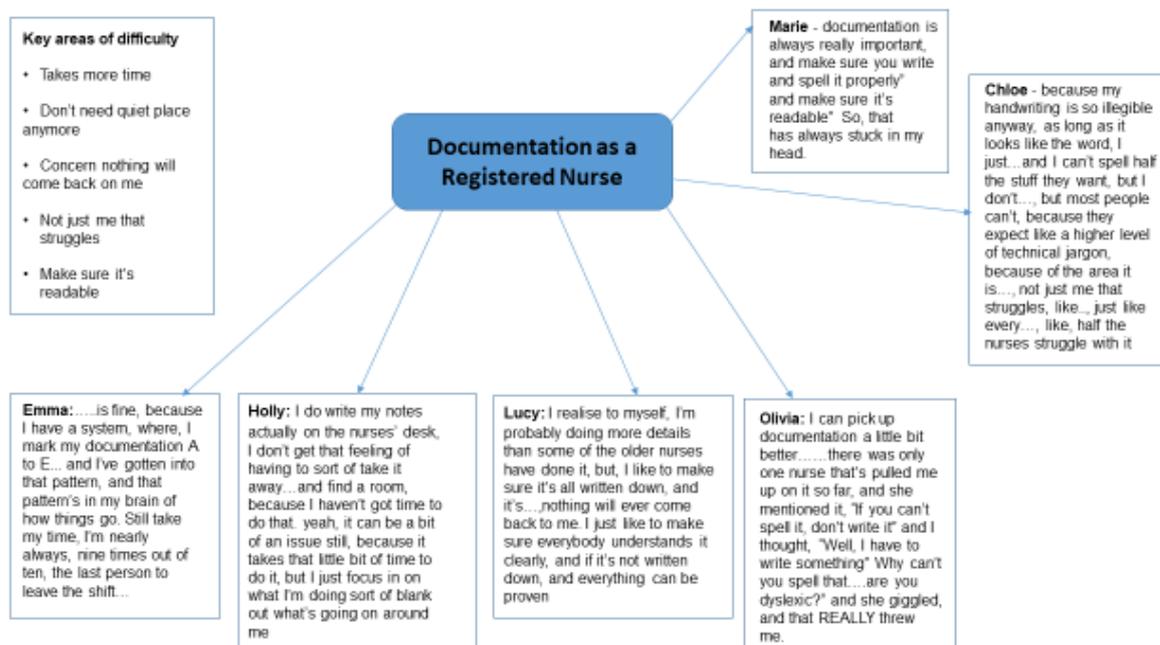
Generally, there is evidence of some nurses still expressing some embarrassment or fear of handover, but in contrast, others claim they are comfortable with it and it does not cause any major issues; therefore, there is a variable perception of clinical handover amongst the participants.

#### 5.4.2.6 Summary of Findings – Registered Nurses, Documentation

A number of commonalities were identified through this theme. One of which was a number of the nurses highlighted their difficulty with spelling, particularly spelling more difficult to pronounce words, as well as grammar. Emma spoke of her strategy to think in pictures and patterns and the use of triggers to help her documentation, particularly her spelling. She also spoke of a lack of a quiet space to write and commented she was always the last to leave because of the increased time she needs to complete her

documentation. Holly commented she no longer needed a quiet space to write her documentation and had learnt to blank out things around her to aid her. Additionally, she described how she has to read back what she has written if she is distracted whilst writing. Lucy spoke of how she checks grammar and the format of her documentation. She also described how she is getting used to spelling more complicated words and thus, they are becoming easier as she gets more familiar with them.

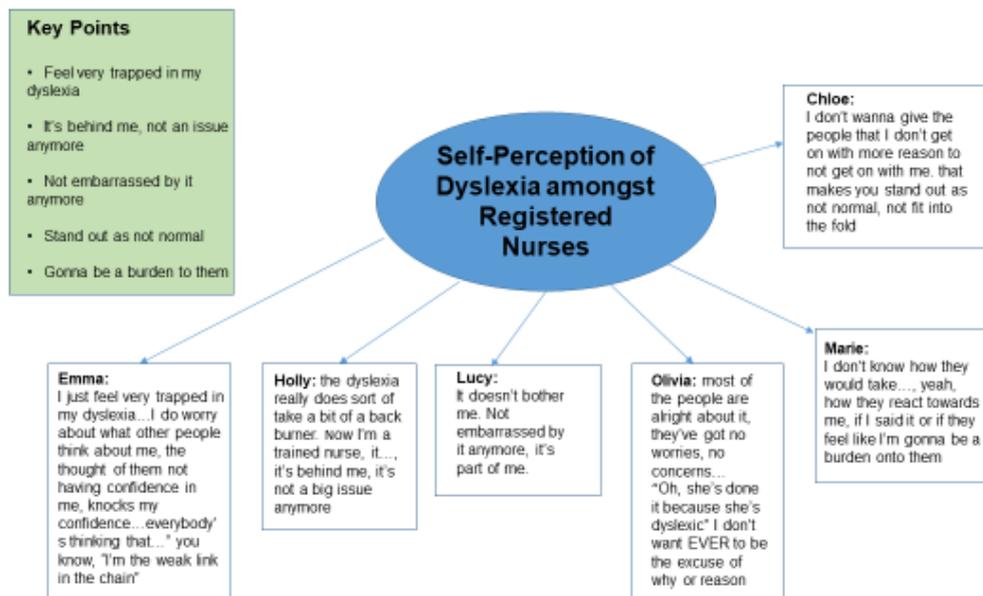
Olivia spoke of an incident where she had to ask another nurse how to spell a certain word whilst writing. The nurse reacted in a patronising manner: 'Why can't you spell that, are you dyslexic?' On realising Olivia was actually dyslexic, Olivia commented: 'the nurse was embarrassed'. This incident demonstrated a rather flippant reaction to a spelling difficulty alongside that of dyslexia. Marie commented on being conscious of getting her spelling right. Chloe spoke of her handwriting being quite illegible at times and the difficulty of spelling 'technical jargon', but commented that many other nurses struggle with the 'technical jargon'. Documentation, therefore, remains a difficulty for some as registered nurses, but some commented that it has become easier during the months they have worked as registered nurses (see Figure 5.16).



**Figure 5.16 – Summary of dyslexic registered nurse comments on documentation**

#### 5.4.2.7 Summary of Findings – Registered Nurses, Self-perception

What was evident was the difference in the self-perceptions of some of the nurses from when they were students to how they now felt about themselves as registered nurses with dyslexia (see Figure 5.17 below):



**Figure 5.17 – Summary of dyslexic registered nurse comments on self-perception**

Emma described how she felt ‘very trapped in her dyslexia’ and worries about what others think of her, and commented ‘others see me as the weak link in the chain’. In contrast, Holly commented that dyslexia is now on ‘a bit of a back burner’ and that ‘it’s behind me... not a big issue anymore’. Lucy commented it does not bother her anymore or she is not embarrassed by it and stated ‘it’s part of me’. Olivia described how she did not want her dyslexia to be seen as an excuse for something she might have done in error; rather, she wanted this to be seen as part of her being human, not dyslexic. Marie worried she would be a burden to others because of her dyslexia. Chloe described her dyslexia as just one more thing that makes you stand out as not normal or being able to ‘fit into the fold’. These are quite contrasting self-perceptions. Some, such as Holly and Lucy, feel differently about their dyslexia than when they were students and appear to be accepting of it, almost quite positive in the sense you should

not be ashamed of it or 'it's part of me'. In contrast, Emma, Marie and Chloe still view dyslexia quite negatively and Olivia wishes others not to view her dyslexia as an excuse. This evidence suggests that some of the nurses still feel stigmatised or marginalised by their dyslexia.

### **5.4.3 Step 3 – Developing Emergent Themes**

This is the first chapter that has presented the analysis of this study focusing specifically on the six nursing students detailed in phase 1 (Figure 5.1) identified as case 1 and the same six newly registered nurses detailed in phase 2 (Figure 5.2) identified as case 2.

In summary, following the systematic steps of IPA, the interview data was first read and re-read (Step 1) with early initial observations and thoughts from this first step listed in Table 5.1 (Case 1 – Nursing Students) and Table 5.5 (Case 2 – Registered Nurses). Initial noting of the data transcripts (Step 2) was undertaken, as evident in Table 5.2 (Case 1 – Nursing Student) and Table 5.6 (Case 2 – Registered Nurse) in this chapter. In step 2, the initial noting developed initial themes from each case as listed in Tables 5.7 and 5.8 below:

**Table 5.7 – Case 1 – six nursing students’ initial themes (phase 1)**

A. Disclosure of dyslexia
B. School experiences
C. Drug administration
D. Documentation
E. Self-perception
F. Clinical handovers

**Table 5.8 – Case 2 – six registered nurses’ initial themes (Phase 2)**

A1. Changes since becoming a registered nurse
B1. Disclosure of dyslexia
C1. Familiarity/confidence in nursing tasks
D1. Drug administration
E1. Clinical handovers
F1. Documentation
G1. Self-perception

Step 3 of IPA involves the development of emergent themes from the initial analysis of the data. This is evident in the example transcriptions in Appendices 1 and 2 in the third column of each of these tables, where key themes have been noted from each participant, namely case 1 and case 2. These themes have been placed into a

diagrammatic format to highlight emergent themes from each initial theme. The following (A and G1) are examples of these diagrams (Figures 5.18 and 5.19.).

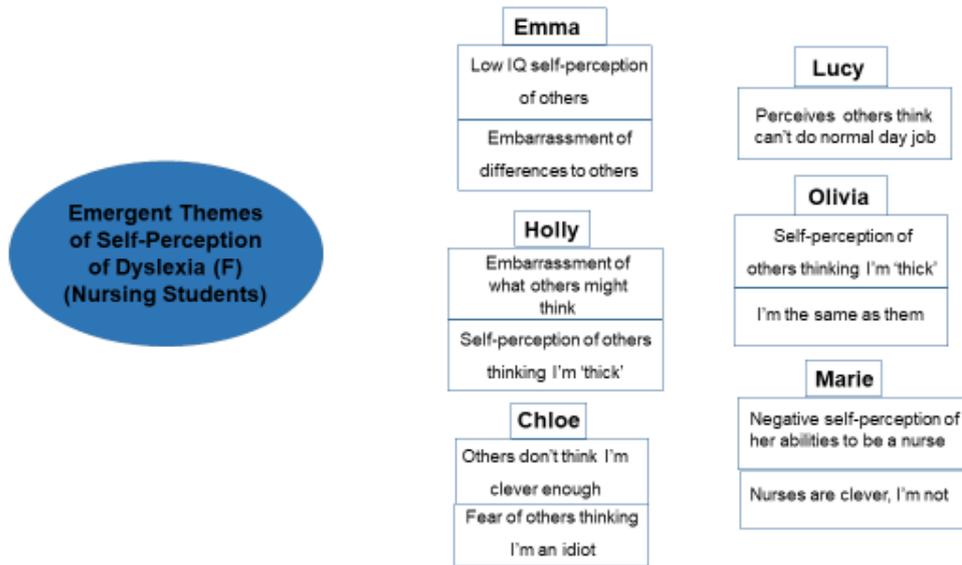


Figure 5.18 – Emergent themes – self-perception of dyslexia (student nurses)

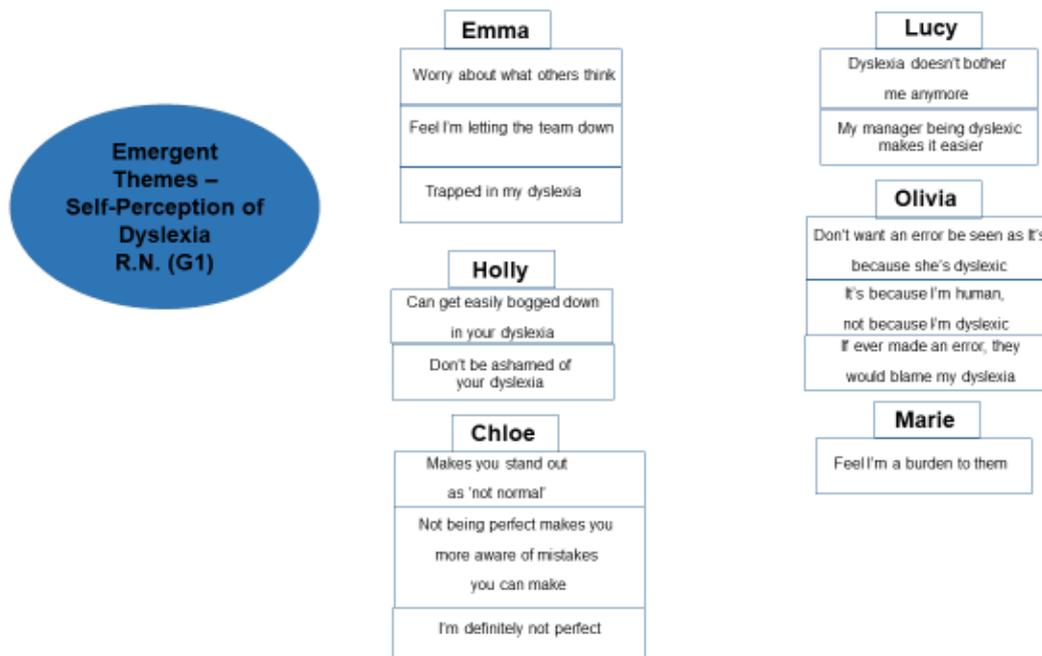


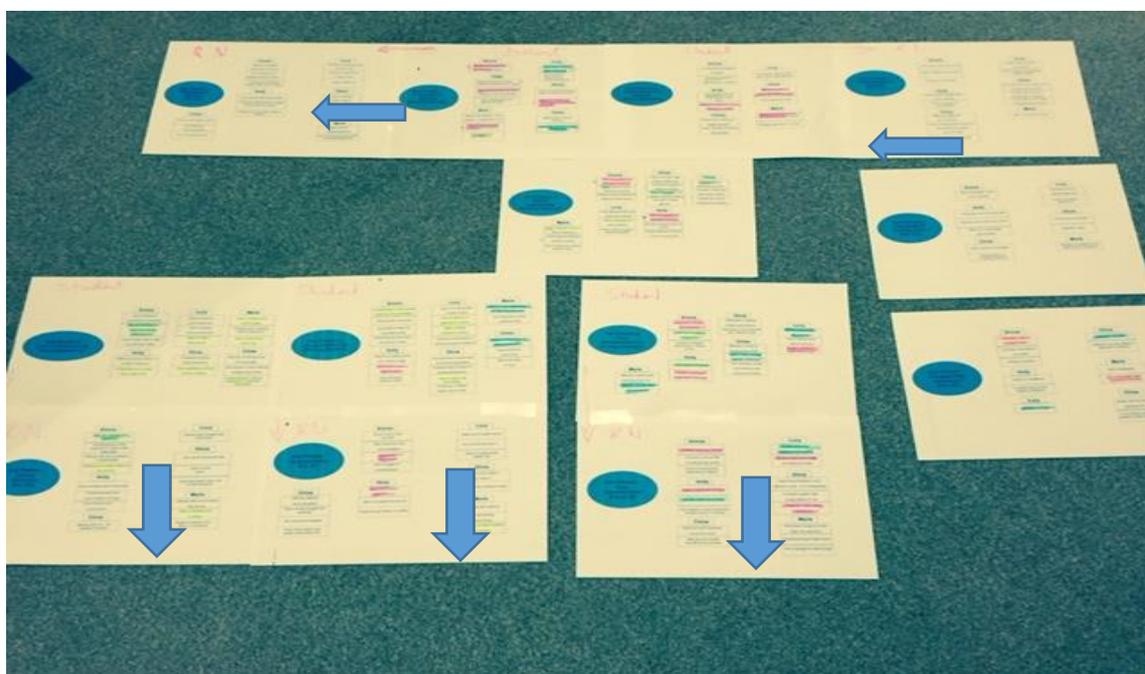
Figure 5.19 – Emergent themes – self-perception of dyslexia (registered nurses)

All emergent themes for registered nurse participants (A1 to G1) are located in Appendix 18. The next stage in the process of emergent themes was to examine all the themes in their diagrammatic format and begin to identify connections across these emergent themes, which moves on to step 4 of IPA.

#### **5.4.4 Step 4 Searching for Connections across Emergent Themes**

The aim of step 4 was to seek and identify patterns across themes. Initially case 1, (nursing students) and case 2 (registered nurses) is examined to identify patterns. Connections across other cases in this study, namely cases 3, 4 and 5 (mentors, tutors and preceptors) are detailed in Chapter 6.

Cases 1 and 2 were set out into emergent the themes listed in Tables 5.7 and 5.8. Photo 5.1 shows these emergent themes from case 1 and 2 in the early process of making connections across these two cases



**Photo 5.1 Emergent themes from case 1 and case 2**

Firstly, the themes that contrasted between the participants as nursing student and the same participants later as registered nurses were set together side by side. This process has been indicated by the insertion of blue arrows on Photo 5.1 to identify how this was done. These specific emergent themes are highlighted as follows in Table 5.9:

**Table 5.9 – Contrasting emerging themes between case 1 and case 2**

<b>Case 1 – Student</b>		<b>Case 2 – Registered Nurse</b>
C. Drug administration		D1. Drug administration
D. Documentation		F1. Documentation
E. Clinical handovers		E1. Clinical handovers
F. Self-perception of dyslexia		G1. Self-perception of dyslexia
A. Disclosure of dyslexia		B1. Disclosure of dyslexia
<b>A1 – Changes since becoming a registered nurse</b>		

These six themes in Table 5.9 linked to emergent theme ‘Changes since becoming a registered nurse’, link directly to research question 2a:

**RQ 2a How might these influences and experiences change/be changed as they adapt and learn to work as a registered nurse with dyslexia?**

Theme A1 – Changes since becoming a registered nurse merge across both cases, hence its position at the bottom of the table, directly linking to research question 2a. Additionally, some outlying themes were not purposely contrasting between other emerging themes between case 1 and case 2. These outlying themes were as follows:

- School experiences (case 1)
- Familiarity/confidence in nursing tasks (case 2)

However, like other themes, these were noted at the reading and re-reading stages (step1) of IPA and thus were analysed in further depth and detail in the initial noting of transcription data stage (step 2). Smith et al. (2009) remarked that during the

organisation of analysis at step 4, not all emergent themes might be incorporated into this stage, some may be discarded. The following outlines emergent themes across cases 1 and 2 some of which were discarded at this stage. Each key statement taken from each emergent theme is numbered n1, n2 etc. which refers to the number of participants who made the same or similar statements.

### **Case 1 (Nursing Students) – Drug Administration**

- Fear of making drug error (n2)
- Double and/or triple checking drugs (n3)
- Paranoia over checking drugs (n1)
- Difficulty with pronunciation of drugs (n2)
- Non-dyslexic nurses have difficulty with drug pronunciation (n1)
- Difficulty in reading Drs' writing (n1)

### **Case 2 (Registered Nurses) – Drug Administration**

- Double/triple checking of drugs (n4)
- Similar sounding drug names difficult (n2)
- Computer system makes reading drugs easier (n1)
- Non-dyslexic nurses also have similar difficulties (n3)
- Use of Google to check drug spelling (n1)
- Would normal person make same mistake? (n1)

### **Case 1 – (Nursing Students) – Documentation**

- Embarrassment/fears of others reading my writing (n3)
- Fear of spelling word and others' reactions (n1)
- Use of quiet area (n2)
- Writing out first on separate paper before main documentation (n3)
- Takes longer to write (n1)

### **Case 2 – (Registered Nurses) – Documentation**

- Need quiet area to write (n1)
- Don't need quiet area anymore (n1)
- Difficulty reading others' writing (n1)
- Other nurses struggle with spellings (n1)
- Used to more complicated words (n1)
- Challenged over inability to spell (n1)
- Take more time over documentation (n1)

### **Case 1 (Nursing Students) – Clinical Handovers**

- Embarrassment of what others think (n2)
- Worry/fear of reading aloud in handovers (n3)
- Embarrassment of being laughed at in handover and impact of this (n1)
- Difficulty keeping up in handovers (n1)
- Purposely avoiding handovers (n1)

### **Case 2 (Registered Nurses) – Clinical Handovers**

- Difficulty with pronunciation of words (n2)
- Embarrassment over pronunciation of words (n1)
- Difficulty keeping up with handovers (n1)
- Nothing has changed with handovers (n1)
- Absolutely awful when did first handover (n1)
- Missing bits out – not reading it properly (n1)
- Reading out to others makes me nervous (n1)

### **Case 1 (Nursing Students) – Self-perception**

- Embarrassment of difference from others (n1)
- Self-perception of others thinking I'm thick/low IQ (n4)
- Others don't think I'm clever enough (n2)
- Perceive others think I can't do a normal day job (n1)

### **Case 2 (Registered Nurses) – Self-perception**

- Dyslexia doesn't bother me anymore (n1)

- Manager being dyslexic made it easier (n1)
- Don't want an error to be seen as because I'm dyslexic (n1)
- Feel I'm a burden to them (n1)
- Makes you stand out as not normal (n1)

### **Case 1 (Nursing Students) – Disclosure**

- Personality of mentor affects disclosure (n2)
- Negative self-perception from others about dyslexia influences disclosure (n3)
- Disclose to prevent negative self-perceptions from others (n1)
- Actual dyslexia disclosure not threatening at all (n1)

### **Case 2 (Registered Nurses) – Disclosure**

- Disclosure of dyslexia gives reason why I'm slow/slow thought processes (n2)
- Disclosure to avoid being seen as useless
- Only disclose if I have a problem, no one needs to know (n1)
- Presence of glasses means I have to disclose (n2)
- Disclosure of dyslexia is ok, it's who I am, doesn't bother me, it's who I am (n1)
- Helpful mentor initiated disclosure (n1)

Examining these collective contrasting themes together, next to each other, a number of patterns emerged. Firstly, the word embarrassment and fear as well as negative self-perception of others appeared quite frequently across a number of themes including disclosure, clinical handovers, documentation and self-perception. Secondly, this embarrassment and fear appeared to be linked to tasks such as spelling, writing and clinical handovers. These emerging patterns are summarised in Table 5.10

In summarising these themes across these cases, the process of clustering them from each case in an attempt to identify superordinate themes from each individual and later master themes could be further developed. This process began to show patterns

across themes. The following Table (5.10) summarises the superordinate themes across comparative cases between the student nurses and later when they become registered nurses. A number of themes are highlighted in bold to identify similarities between themes in each case.



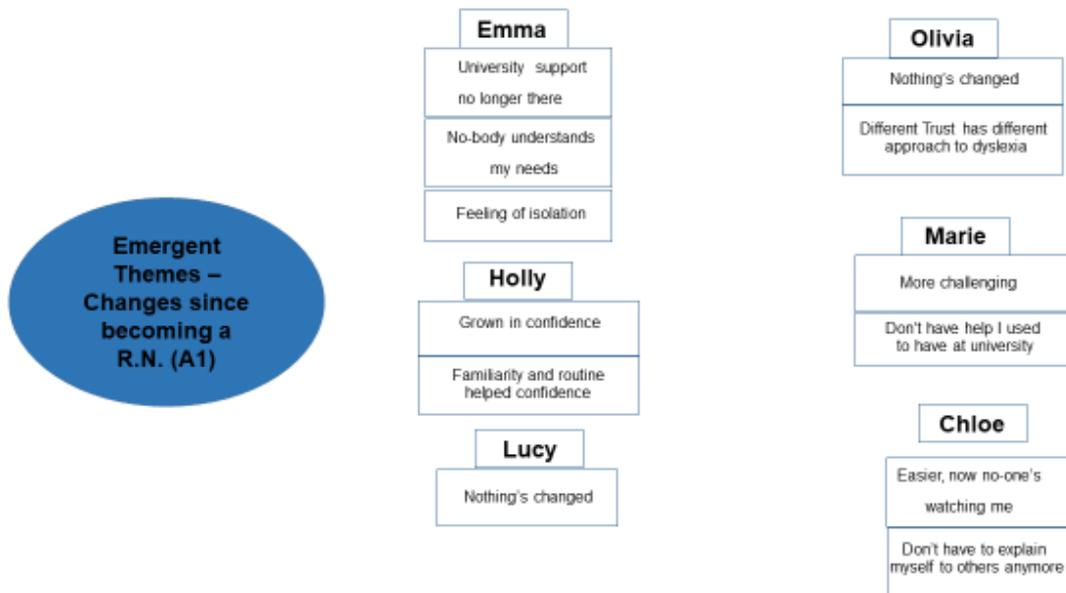


	<p><b>Helpful mentor initiated disclosure</b></p> <p>Presence of glasses means have to disclose</p> <p>Disclosure of dyslexia is ok, it's who I am</p>
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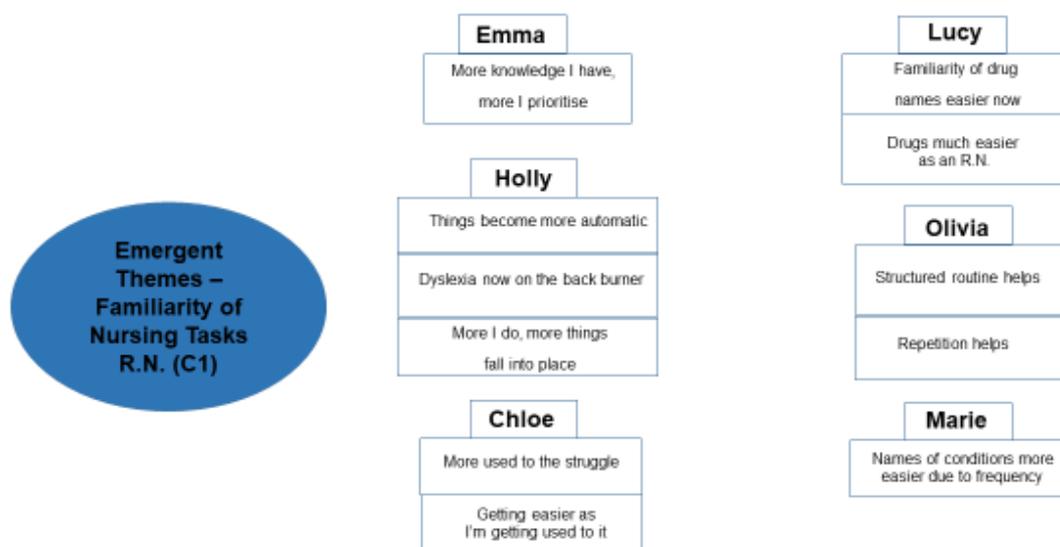
As highlighted previously, further themes from the student nurse/registered nurse participant group include the following:

- A1 – Changes since becoming a registered nurse
- C1 – Familiarity/confidence in Nursing Tasks

As in previous themes, these were created into a diagrammatic format to highlight emergent themes. These emergent themes are shown in Figures 5.20 and 5.21 below:



**Figure 5.20 – Emergent themes – changes since becoming a registered nurse (Registered Nurses)**



**Figure 5.21 – Emergent themes – familiarity/confidence in nursing tasks (registered nurses)**

Theme A1, 'Changes since becoming a registered nurse' is quite a central theme in terms of significantly contributing to research question 2a, identifying the changes that are apparent to a newly registered nurse with dyslexia. The common themes from this theme are listed below:

**A1 Changes since becoming a registered nurse**

University help/support no longer there (n2)

Nothing's changed (n2)

Nobody understands my needs (n1)

Feeling of isolation (n1)

More challenging (n1)

Easier, now no one's watching me (n1)

Grown in confidence/ familiarity and routine helped confidence (n1)

A closer examination of these themes collectively indicated two participants claimed nothing had changed; however, later steps may indicate more specific changes when patterns are examined across other themes. One participant claimed no one understands her needs and she feels isolated. Another participant described how she had grown in confidence, indicating differing and opposing responses.

The final theme, C1 – ‘Familiarity/confidence in nursing tasks’, identifies that as registered nurses, the participants’ spoke of increased confidence and familiarity with nursing tasks. The common themes from this theme are listed on the following page.

### **C1 Familiarity/confidence of Nursing Tasks**

Things become more automatic, more I do, things fall into place (n1)

More knowledge, more I prioritise (n1)

Familiarity of drug names easier now/drugs much easier as an RN (n1)

Structured routine, repetition helps (n1)

Names of conditions much easier, due to frequency (n1)

Getting easier as I’m getting used to it (n1)

Dyslexia now on the back burner (n1)

The first six themes are underlined, as a common theme runs through them collectively in terms of the more I do things, the more knowledge I get, familiarity of drug names, repetition and routine helps. This suggests, amongst all the participants, evidence of becoming more confident and familiar with tasks as they progress as registered nurses. One statement ‘dyslexia now on the back burner’ provides interesting further

detail and questions whether in the case of this participant, dyslexia is something she is less conscious of as she has become a registered nurse.

#### 5.4.5 Step 5 – Moving to the next Case

Step 5 involved moving to the next case. However, it should be noted this has already been undertaken, as I have moved from case to case examining each of them individually and then collectively as is evident throughout step 4.

#### 5.4.6 Step 6 – Looking for Patterns across Cases

This step involved examining all cases and looking for a pattern across these cases. Firstly, I looked across the emerging themes of cases 1 and 2, namely the nursing students who later become registered nurses. In undertaking this step, what are described by Smith et al. (2009) as master themes are identified. Following the process of looking across all superordinate themes identified in step 4, a number of master themes began to emerge. Table 5.11 outlines these themes with reference to direct transcription statements made from each participant.

**Table 5.11 – Table of master themes from students/registered nurses**

<p><b>Embarrassment about dyslexia/negative self-perception of what others think</b></p> <p>Embarrassment of differences from others – Emma (student)</p> <p>Embarrassment of what others might think – Holly (student)</p> <p>Others don't think I'm clever enough – Chloe (student)</p> <p>Makes you stand out as 'not normal' – Chloe (RN)</p> <p>Self-perception of others thinking I'm 'thick' – Olivia (student)</p> <p>Perceives others think I can't do normal day job – Lucy (student)</p> <p>Feel I'm a burden to them – Marie (RN)</p> <p>Nurses are clever, I'm not – Marie (student)</p> <p>Worry about what others think – Emma (RN)</p>
<p><b>Difficulty with aspects of literacy</b></p>

Difficulty with new words – Emma (student)  
Difficulty with pronunciations – embarrassed – Emma (RN)  
Difficulty spelling technical jargon – Chloe (RN)  
Fear of not being able to spell a word – Lucy (student)  
Writing things out twice to avoid spelling errors – Olivia (student)  
Difficulties in reading written prescriptions – Olivia (student)  
Difficulty pronouncing drug names – Lucy (student)  
Difficulty in pronunciation of drug names – Marie (student)  
Embarrassment over pronunciation of drugs – Holly (RN)

**Anger/Frustration/negative school experiences**

Anger dyslexia wasn't picked up at school – Emma (student)  
Anger and frustration over negative teacher reaction – Olivia (student)  
Frustration over difficulties at school – Chloe (student)  
Lack of recognition of difficulties at school – Holly (student)  
Initial embarrassment about dyslexia at school – Lucy (student)  
Hated idea of being different at school – Olivia (student)  
Fear of reading out loud at school – Marie (student)

**Increased confidence/familiarity with tasks now registered nurse**

More knowledge I have, more I prioritise – Emma (RN)  
Things become more automatic – Holly (RN)  
More I do, more things fall into place – Holly (RN)  
Getting easier as I'm getting used to it – Chloe (RN)  
Familiarity of drug names easier now – Lucy (RN)  
Names of conditions much easier due to frequency – Marie (RN)  
Repetition helps – Olivia (RN)  
Have become more familiar with frequent drugs – Olivia (RN)  
More confident with handovers – Holly (RN)  
More complex words easier now – Lucy (RN)

**Hypervigilance in drug administration**

Paranoia of checking and checking – Emma (Student)

Constant checking of drugs – Emma (RN)

Constant checking of drugs takes me longer – Holly (Student)

Check, check and re-check – Holly (RN)

Always double and triple check drugs – Lucy (Student)

Double, triple times check, but others do it also – Lucy (RN)

**Differences in disclosure of dyslexia**

Disclose dyslexia to prevent negative perceptions from others – Holly (Student)

Personality of mentor impacts on disclosure – Chloe (Student)

Disclosure influenced by others' negative perceptions of dyslexia – Olivia (Student)

Personality of mentor affects disclosure – Lucy (Student)

Negative self-perception from others of dyslexia affects disclosure – Emma (Student)

Mentor was dyslexic, made it easier to disclose – understood it more – Marie (Student)

Disclosure of dyslexia gives reason why I'm slow – Emma (RN)

Disclosure appropriate to explain slow thought processes – Holly (RN)

Only disclose if I have a problem – Chloe (RN)

Disclosure of dyslexia is ok. It is who I am – Lucy (RN)

Don't disclose unless I have to – Olivia (RN)

Helpful mentor initiates disclosure – Marie (RN)

Non-disclosure as I don't want to be treated differently – Marie (RN)

**5.4.7 Summary of Chapter**

This chapter has analysed the transcribed interview data of the nursing students categorised as case 1 and the registered nurses categorised as case 2. However, as reiterated at the beginning of this chapter, the nursing students and the registered

nurses are the same participants and thus are the key components of the longitudinal element of this study. Using the systematic IPA step-by-step process of analysis and interpretation, the data was analysed in distinct sections in the transcribed interview data tables, which are evident in the example tables included in Appendices 1 and 2, where a number of emergent themes emerged. Each emergent theme identified in this chapter is supported by a short summary of the findings, which will be outlined in further detail in Chapter 7. Throughout this analytical process, a number of master themes were identified. These themes will be considered alongside other cases, namely mentors, tutors and preceptors from the other elements of the study to identify emerging patterns across these other cases from Chapter 6.

## **CHAPTER 6: Analysis and Findings of Research Data – Mentors, Tutors and Preceptors**

### **6.1 Introduction**

This chapter continues the process of analysing transcribed interview data from Chapter 5, but now focuses specifically on those participants who supported the nursing students and subsequent registered nurses at the pre-registration and post-registration level, namely the mentors and nurse tutors in phase 1 of the study and preceptors in phase 2 (Figures 5.1 & 5.2). As in chapter 5, the stages of IPA will be followed, outlined by Smith et al. (2009) as listed below:

1. Reading and re-reading
2. Initial noting
3. Developing emergent themes
4. Searching for connections across emergent themes
5. Moving to the next case
6. Looking for patterns across cases

Each group of participants in this chapter is categorised as a case number as in the previous chapter. The following case numbers were adopted to categorise the remaining groups of participants:

**Case 3** – Mentors

**Case 4** – Nurse Tutors

**Case 5** –Preceptors

## 6.2 Case 3 – Mentors

The mentors supported the nursing students during the last months of their time as a nursing student. The specific characteristics of each mentor are detailed in Table 4.3 in section 4.3.2 of Chapter 4. Each mentor is linked directly to the students in this study by virtue of being a personal mentor to one of the students. Therefore, as outlined in Figure 5.1 – phase 1 of this study, each student is linked to a specific mentor as outlined in Table 6.1

**Table 6.1 – Mentor links to students in the study**

Emma	Mentor 1A
Holly	Mentor 2B
Lucy	Mentor 3C
Marie	Mentor 4D
Olivia	Mentor 6E
Chloe	Mentor 7F

However, as detailed in Chapter 4, two mentors did not take part in the study. Mentor 6E was unable to be contacted and mentor 7F declined to take part, which is indicated by the shading of both of these mentors in Table 6.1. Therefore, data from mentors 1A to 4D is only analysed in this chapter.

### 6.2.1 Step 1 – Reading and Re-reading of Data

As in cases 1 and 2, step 1 involved being immersed in the data by reading and re-reading the transcripts as well as listening to the audio recordings over a period of weeks. During this initial process, I made a number of notes and observations, outlined in Table 6.2:

**Table 6.2 – Initial notes and observations from mentor transcripts**

1. Demonstrated a limited knowledge of dyslexia
2. No or little training in the support of nursing students with dyslexia
3. Overall positive experiences mentoring a nursing student with dyslexia
4. Some concerns over lack of disclosure from dyslexic students
5. Overall, dyslexia should not affect ability of a nursing student
6. One out of the four mentors had an overly negative perception of dyslexia
7. The remaining three mentors had a generally positive perception of dyslexia

As highlighted in Chapter 5, this step does result in the emergence of early themes or initial themes and as Smith et al. (2009) described, in the case of large amounts of data, such as in this study, themes can be identified at case level. Therefore, in respect of this, the mentors in case 3 were divided into initial themes G, H, I, etc. with a focus upon research question 2 as follows:

**RQ 2. What are the perceptions, experiences and understandings of dyslexia amongst mentors, nurse tutors and preceptors who support and guide dyslexic nursing students/nurses through education and clinical practice both at pre-registration and post-registration level?**

This question focuses specifically on the mentors and nurse tutors who supported the nursing students at the pre-registration level and preceptors who supported registered nurses at the post-registration level. The following Table 6.3 is one example of the analysed transcriptions from the mentors. A selection of these transcriptions is located in Appendix 3.

**Table 6.3 – Interview with mentor 1A (theme H), disclosure of dyslexia**

<p><b>Interview 1, Mentor 1A, p. 12</b>  <i>BG Many nursing students who have dyslexia, are actually often unwilling to disclose their dyslexia to you, can you understand their reasons for not disclosing it?</i></p> <p><b>Mentor 1A:</b> Yeah, I think uhhh..., I mean, anyone..., well, again, relating to my own experiences, I mean, people with a disability, there's always that fear of stigmatisation, and being labelled, if you like.</p> <p><b>You know, uhhh, you know, people are..., I think people are reluctant to come forward, because they're worried about what people are going to think, and how they're going to react, and what..., how is it going to influence their perception of you, and things like that,</b></p> <p>But..., but I mean, again, you know, I mean with that..., mature student anyway, so, you know, I mean, I can understand it if somebody was very</p>	<p>Highlights that relating to his own experiences, admitting previously of his own disability that's there's always fear of stigmatisation and being labelled</p> <p><u>Clearly aware from his own experience of both stigma and labelling with regard to disability, argued that someone with or without a disability might be aware of this, but to what degree and in what context</u></p> <p>Describes this issue further in terms of reluctance of people with disabilities are worried about what others might think and their reaction and perception</p> <p><u>Again shows an acute awareness of what people with disabilities must feel</u></p> <p>Makes contrast between mature students and a young 18-year old</p>	<p>Always fear of stigma and labelling</p> <p>Worried what people are going to think of them</p>
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young, like an 18-year old, something like that, it might be a different sort of proportion.	student in terms of the impact or proportion of disclosure  <u>An insightful contrast that is not really considered in terms of disclosure between ages of student</u>	
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There follows a narrative discussion of the findings from the mentor interviews taking each emergent theme in turn. However, diagrammatic representations of these emergent themes are included at the conclusion of this section.

#### *6.2.1.1 Summary of Findings – Understanding of Dyslexia*

The analysis of this section of the data presents an understanding of dyslexia from the mentors with emphasis upon literacy difficulty. This is evident with all four mentors highlighting the difficulty of getting words and letters mixed up, difficulty unscrambling words, recognising letters and struggling with reading and writing. This tentatively presents perhaps a societal view of dyslexia with a focus upon mainly literacy difficulty.

#### *6.2.1.2 Summary of Findings – Disclosure of Dyslexia*

This theme highlights the issue of disclosing dyslexia by nursing students from the mentor’s perspective. Some mentors (mentors 1A & 3C) expressed an understanding of why they might disclose; particularly citing stigmatisation and embarrassment. However, others appeared much less understanding. Mentor 3C described that dyslexia should be at the forefront of their mind and if they are having difficulties at work, they should tell their mentor. If it presents as a problem, she stated she would not have much compassion for them if they had not disclosed their dyslexia. Mentor 2B did add she understands that others might judge them. However, her emphasis was upon the issue of informing their mentor of their difficulty. Mentor 4D again cites

embarrassment as a reason for non-disclosure, but emphasised a need to be open, 'don't cover it up and don't be ashamed of it'. This evidence presents a contrasting view of the disclosure of dyslexia, with some mentors understanding the stigma and embarrassment surrounding it, others placing emphasis of disclosure upon either clinical safety and the importance of an awareness of a difficulty a nurse might have in practice or a need not to cover it up.

#### 6.2.1.3 Summary of Findings – Personal Experience of Mentoring a Student *Nurse with Dyslexia*

This theme emerged as each mentor was asked for a broad account of their experiences mentoring a nursing student with dyslexia. The accounts were quite different in relation to this experience. Mentor 1A described how he looks for a student's ability to do the job with or without a disability, and commented he had a disability himself and it had not affected his ability to do the job. He further commented that he was not prejudiced against any kind of disability. Mentor 1A also added Emma was the best student he had ever had.

Mentor 2B described an incident where she had asked Holly to produce a piece of written work and on checking this work, asked Holly 'Are you stupid or dyslexic', not realising at this stage she was dyslexic. She also went on to comment she was surprised Holly was doing nursing and highlighted the potential danger of a nurse with dyslexia. Clearly, this mentor candidly expressed concerns about a nursing student with dyslexia in practice. Mentor 3C spoke of Lucy in respect that it did not really impinge on her work, just with regard to her documentation, stating; 'it might take a bit longer'. Mentor 4D commented that she was surprised Marie was dyslexic, as her documentation was fine. She also commented that if she had known at the beginning

she was dyslexic, 'I would have kept an extra eye on her'. This evidence suggests a variant experience of mentoring a nursing student with dyslexia, which also revealed the mentors' own perceptions of dyslexia, some of these questioning ability and safety contrasted by others demonstrating an understanding and supportive approach.

#### *6.2.1.4 Summary of Findings of No Inclusion of Dyslexia on Mentor Training Courses*

This was a very simple yes or no answer, which asked if the mentors could recall any mention of dyslexia on mentor training courses. All mentors stated they could not recall any mention of either disability or dyslexia. This suggests a need for greater awareness of disabilities and the inclusion of such information on mentoring training courses concerning disabilities amongst nursing students in practice.

#### *6.2.1.5 Summary of Findings of Perception of Nurses with Dyslexia*

To some degree, this theme overlaps with the mentors' experiences of mentoring a nursing student with dyslexia, in that their self-perceptions of dyslexia were also revealed during these discussions. Mentor 3C commented that 'many people have come out' referring to those who had disclosed their dyslexia. This was an interesting statement, which has commonalities to a term often used to describe those who have revealed their homosexuality, suggesting the mentor is perhaps making a connection between the stigma surrounding both homosexuality and dyslexia. Mentor 2B commented very strongly on her fears surrounding a nurse with dyslexia stating it was not only a 'problem for her, but also the patient she is looking after ...potentially dangerous'. Mentor 4D commented 'my main fear would be giving the wrong drug' but continued, 'There are worst things out there' and 'If they have gone this far, they must be ok'. Therefore, there are contrasting fears surrounding safety, with one mentor warning of potential danger but another mentor commenting if the student had

progressed this far, they should be at less risk of errors, despite still expressing a fear of giving the wrong drug.

### **6.2.2 Step 3 – Developing Emergent Themes (Mentors)**

As in Chapter 5, in following the IPA step-by-step process, the analysis of the interview data of the mentors was undertaken in step 2 (initial noting), which is evident by the data analysis tables in Appendix 3. The initial themes from the mentors' interview data is listed below in Table 6.4.

**Table 6.4 – Case 3 – mentors' initial themes (phase 1)**

G. Understanding and knowledge of dyslexia
H. Disclosure of dyslexia
I. Personal experience of mentoring a dyslexic nursing student
J. No inclusion of mentor training on dyslexia
K. Perception of dyslexia by mentors

During the process of the initial noting stage of the interview transcriptions, a third column was inserted in the tables to note key themes from emergent themes. These key themes were formatted into the same diagrammatic format as highlighted in Chapter 5 with the students and registered nurse interview data. With direct reference to the mentors, the following figures show these emergent themes:

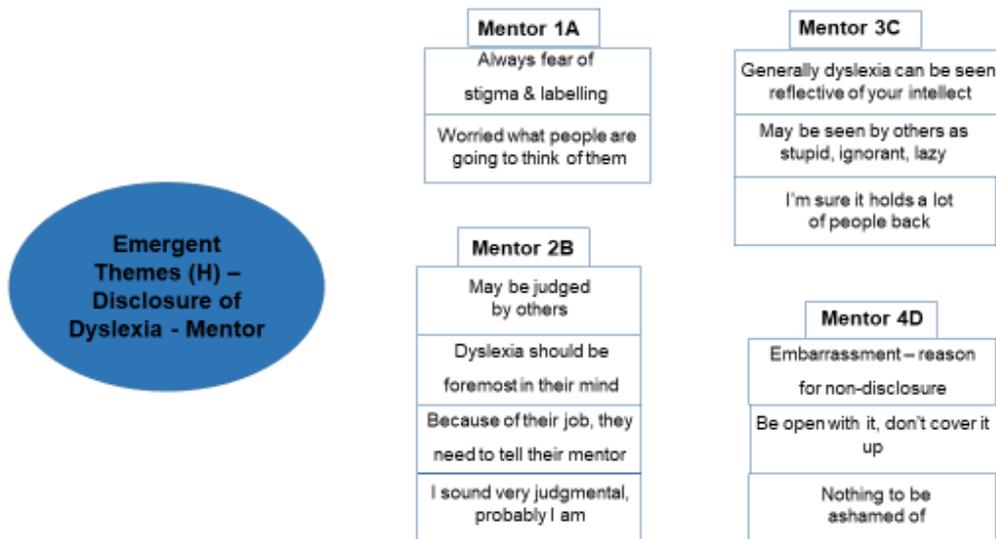


Figure 6.1 – Emergent themes H – disclosure of dyslexia, mentor

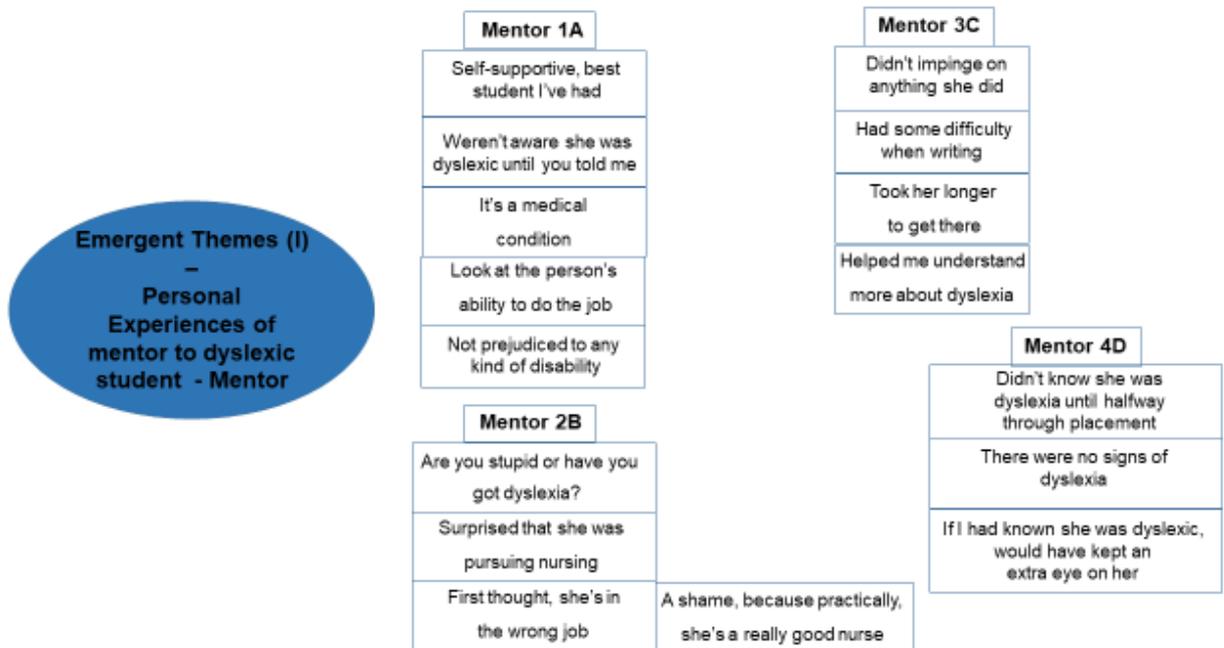


Figure 6.2 – Emergent themes I – personal experiences of mentor to dyslexic student

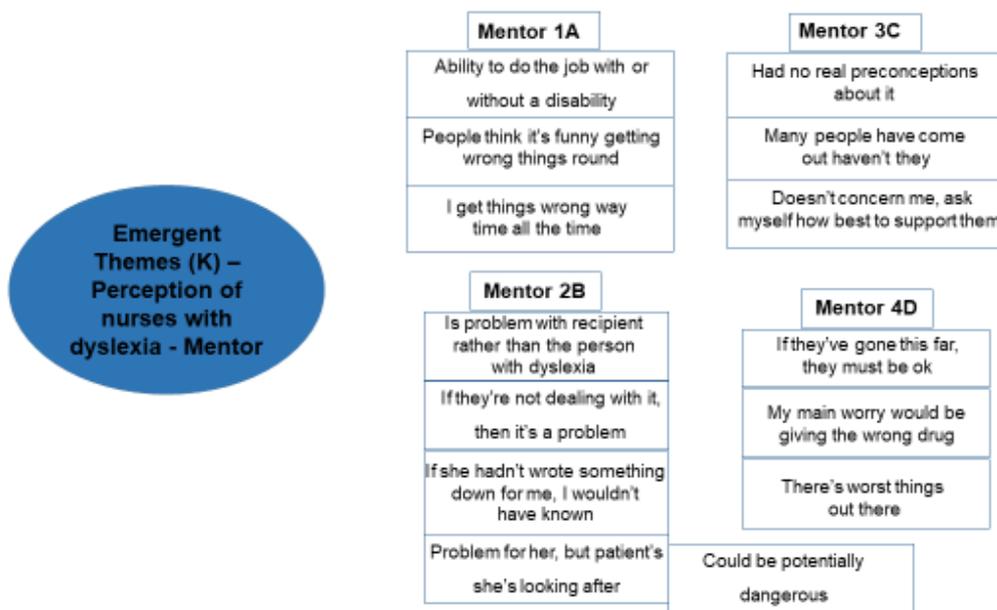


Figure 6.3 – Emergent themes K – perception of nurses with dyslexia, mentor

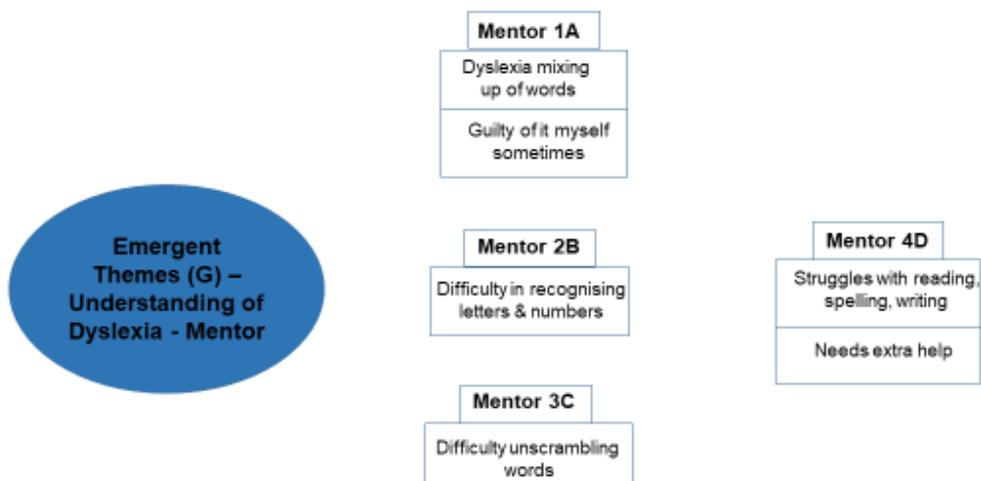


Figure 6.4 – Emergent themes G – understanding of dyslexia, mentor

### 6.2.3 Step 4 – Searching for Connections across Emergent Themes (Mentors)

From these diagrams, early connections were made across emergent themes by laying each diagram alongside each other and using coloured highlighter pens; similarities were noted across themes. Photo 6.1 below demonstrates this process. Additionally, connections were made across emergent themes, indicated in photo 6.1 through the insertion of arrows across these themes.

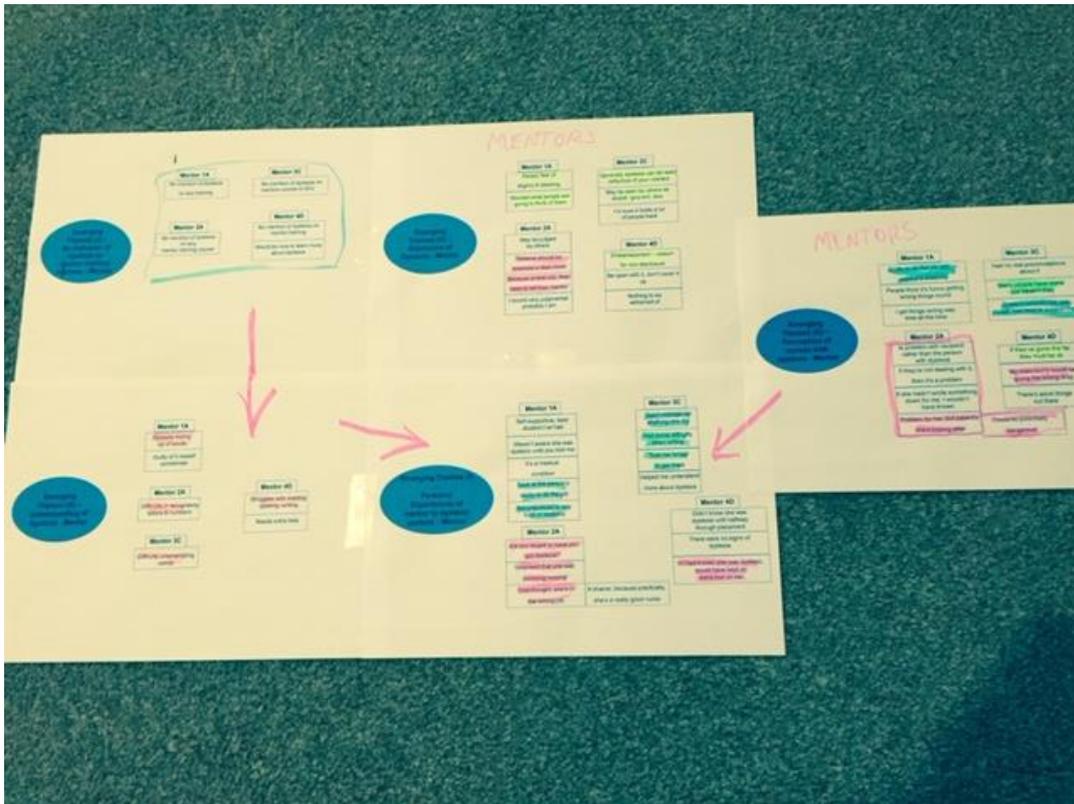


Photo 6.1 Connections across emergent themes – mentors

These connections across these emergent themes are indicated below in Table 6.5.

**Table 6.5 – Connections across emergent themes (mentors)**

Personal experiences of mentoring a dyslexic nursing student	→	Perceptions of nurses with dyslexia
Understanding of dyslexia	→	No inclusion of disability/dyslexia training on mentor course
Understanding of disclosure of dyslexia	→	Perceptions of nurses with dyslexia

These emergent themes and connections across these themes link directly to research question 2a with direct reference to the mentor element of this question highlighted at the beginning of this chapter.

The connection between the initial theme ‘personal experiences of mentoring a dyslexic nursing student’ and ‘perceptions of nurses with dyslexia’ are firstly noted as some mentors, specifically mentor 2B, had quite a negative perception of a nurse with dyslexia, stating that it was a problem for her and the patient she looked after and stated there was a potential danger. Mentor 4D expressed a worry that she might give the wrong drug. In contrast, other mentors 1A and 3C stated no concerns or preconceptions about dyslexia (mentor 3C) or ‘ability to do the job with or without a disability’ (mentor 1A). This is reflected further in their experiences, with mentor 2B stating ‘she’s in the wrong job’ and that she was ‘surprised she was pursuing nursing’, as well as stating ‘are you stupid or have you got dyslexia?’ when the student presented some written work to her. Mentor 4D expressed that she would have kept an extra eye on her if she knew she was dyslexic. The other two mentors again had contrasting comments with mentor 1A stating she was self-supportive and the best

student he had had, and mentor 3C stating dyslexia 'didn't impinge on anything she did'. There are clearly contrasting perceptions of dyslexia amongst these mentors which matches across these two themes.

Additionally, the mentors' understanding of dyslexia appeared to be focused largely upon literacy difficulty stating difficulty with spelling, reading and writing were quite brief in their responses. However, regarding the definition of dyslexia in Chapter 2, the Rose (2009) definition encompasses the literacy difficulties associated with dyslexia that the mentors referred to in their understanding of dyslexia. All the mentors (n4) stated they could not recall any inclusion or mention of dyslexia in their mentor training courses. It is argued this might be then reflected in their overall understanding of dyslexia.

The initial theme of the understanding of disclosure of dyslexia and a connection with perceptions of dyslexia again sees some contrasting comments. All mentors (n4) stated an understanding of the reasons for non-disclosure around stigma, specifically being judged, embarrassment and reflection of intellect. However, mentor 3C stated dyslexia should be foremost in their mind and should inform their mentor because of their job. Mentor 4D stated 'be open with it, don't cover it up, nothing to be ashamed of' again some contrasting comments evident particularly between mentors 3C and 4D and mentors 1A and 3C.

To identify specific common themes from these emergent themes, the following lists similar statements from each participant on each of the emergent themes. Similarities in these statements are categorised by identifying these themes by underlining, italics or in bold:

### **Personal Experiences of mentoring a dyslexic nursing student**

*Self-supportive, best student I've had (Mentor 1A)*

*Didn't impinge on anything she did (Mentor 3C)*

**Surprised that she was pursuing nursing, first thought, she's in the wrong job (Mentor 4D)**

**If I had known she was dyslexic, would have kept an extra eye on her (Mentor 3C)**

Weren't aware she was dyslexic until you told me (Mentor 1A)

Didn't know she was dyslexia until halfway through placement (Mentor 3C)

### **Perceptions of nurses with dyslexia**

Ability to do the job with or without a disability (Mentor 1A)

Had no real preconceptions about it, doesn't concern me, ask myself how best to support them (Mentor 2B)

*If they've gone this far, they must be ok, there's worst things out there (Mentor 3C)*

**Problem for her, but patients she's looking after, could be potentially dangerous (Mentor 2B)**

**My main worry would be giving the wrong drug (Mentor 4D)**

### **Understanding of disclosure of dyslexia**

Always fear of stigma and labelling, worried what people are going to think of them (Mentor 1A)

Generally dyslexia can be seen reflective of your intellect, may be seen by others as stupid, ignorant, lazy (Mentor 2B)

Embarrassment – reason for non-disclosure (Mentor 4D)

May be judged by others (Mentor 2B)

**Dyslexia should be foremost in their mind, because of their job, they need to tell their mentor (Mentor 2B)**

*Be open with it, don't cover it up, nothing to be ashamed of (Mentor 4D)*

### **Understanding of dyslexia**

Dyslexia mixing up of words, guilty of it myself sometimes (Mentor 1A)

Difficulty in recognising letters and numbers (Mentor 2B)

Difficulty unscrambling words (Mentor 3C)

Struggles with reading, spelling, writing, *needs extra help* (Mentor 4D)

On closer examination of these collective themes, a number of common themes begin to emerge, particularly an understanding amongst the mentors of the stigma surrounding dyslexia. Also, there is evidence of a differing, widening perception amongst the mentors of dyslexia from no concerns or no preconceptions to serious concerns around safety in practice. Additionally, there is a limited understanding amongst mentors of the overall impact of dyslexia upon an individual, which might be connected to, as previously highlighted, the fact that there was no mention of dyslexia on the mentor training courses they had previously attended. These themes will be discussed in detail in Chapter 7.

#### **6.2.4 Step 5 – Moving to the Next Case**

As previously highlighted in Chapter 5, moving to the next case has been undertaken and is ongoing within this chapter as I now move from case 3 (mentors) to case 4 (tutors) and case 5 (preceptors), which follows in section 6.8 and 6.9 of this chapter.

#### **6.2.5 Step 6 – Looking for Patterns across Cases**

Step 6 now takes the analytical process of IPA further by identifying patterns across cases. In respect of case 3 – mentors, despite this being only one case, it is important to identify key or master themes at this stage, so further themes can be matched across other cases prior to the discussion. These themes are matched and compared in sections 6.8 and 6.9 in this chapter, in relation to tutors and preceptors.

The common themes that emerged in step 4 are categorised in the following master themes in Table 6.6 below:

**Table 6.6 – Master themes from case 3, mentors**

An understanding amongst mentors of the negative stigma of dyslexia
Concerns amongst some mentors (n2) over safety in practice of a nurse with dyslexia
No concerns or preconceptions at all amongst other mentors (n2) about nurses with dyslexia in practice
Limited understanding of dyslexia – focus upon literacy difficulty
No mention of dyslexia on mentoring training courses

### 6.3 Case 4 – Tutors

Case 4 comprises the tutors outlined in phase 1 of the Record of Interviews – phase 1 (Figure 5.1). Specific characteristics of each tutor are detailed in Table 4.4 in section 4.3.3 of Chapter 4. The tutors supported the nursing students whilst at university, having a direct connection to the students in this study in the context that they were personal tutors to the students and thus were known to each other. However, two of the tutors were not directly connected to two of the nursing students, and more importantly, not known to them. Tutor 1A was a course director rather than a personal tutor to Emma. Additionally tutor 6F was also a course director rather than a personal tutor to Chloe. In Emma's case, I am Emma's personal tutor. Therefore, it was obviously not possible to interview myself. Secondly, in Chloe's case, her own personal tutor did not wish to take part in the study, hence why her course director was approached as an alternative and both consented to take part. Therefore, Table 6.7

outlines the tutors' links to the students in phase 1, but as highlighted, tutor 1A and tutor 6F were not known to their respective nursing students, nor did the nursing students know the tutors, this is indicated through shading of Emma and tutor 1A and Chloe and tutor 6F.

**Table 6.7 – Tutors and nursing students**

Emma	Tutor 1A
Holly	Tutor 2B
Lucy	Tutor 3C
Marie	Tutor 4D
Olivia	Tutor 5E
Chloe	Tutor 6F

As with previous cases, the specific steps of IPA were followed commencing with step 1 – reading and re-reading.

### **6.3.1 Step 1 – Reading and Re-reading**

As with previous cases, the tutors' transcripts were read and re-read and the audio recordings listened to thus allowing an immersion into the data. During this process, I made a number of notes and observations, which are summarised in Table 6.8.

**Table 6.8 – Initial notes and observations from tutor transcripts**

<ol style="list-style-type: none"> <li>1. Greater knowledge of dyslexia</li> <li>2. Know about dyslexia, but unsure how best to support dyslexic students</li> <li>3. Disparity between support at university and support in practice</li> <li>4. Identifies a stigma to being dyslexic</li> <li>5. Daily clinical pressures on mentors can affect support given to dyslexic nursing students</li> <li>6. Difficulties a nursing student with dyslexia may experience, many non-dyslexic nursing students can also experience</li> <li>7. Overall supportive of dyslexic nursing students</li> </ol>
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**6.3.2 Step 2 – Initial Noting**

As highlighted at the beginning of this chapter, Smith et al. (2009) remarked that themes could be identified initially at case level; therefore, as previously, initial themes were identified with a focus upon the nurse tutor element of research question 2 highlighted at the beginning of this chapter. The following Table 6.9 is one example of an analysed transcription from tutor 1A. A selection of these tables are located in Appendix 4.

**Table 6.9 – Interview with tutor 1A, knowledge and understanding of dyslexia (theme M)**

<p><u>Interview 1, Tutor 1A, p. 2</u></p>	<p>Comments that it does affect people differently and some may have severe dyslexia</p>	
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<p><b>Tutor 1A:</b> ...from my experience, it seems to affect people differently. Some people have severe dyslexia.</p> <p><b>Tutor 1A:</b> And it really gets in the way of them achieving.</p> <p><b>Tutor 1A:</b> Their..., in their academic work, and in practice, and some students seem to have adapted, or it's not so bad.</p> <p><b>Tutor 1A:</b> And they can manage. So, I think what I've seen is that lots of students have dyslexia, but it seems to vary in severity from quite mild to quite severe.</p> <p><b>Interview 2, Tutor 1A, p. 4, 5</b></p> <p><b>Tutor 1A:</b> ...I've recently seen somebody's assessment, where it talks about intellectual level. And memory, and so when you see that report... That gives you more of an idea of how</p>	<p><u>Recognises the variability of dyslexia in terms of affecting people differently and also a knowledge of severe dyslexia</u></p> <p>Identifies how dyslexia can get in the way of achieving</p> <p><u>This comment clearly states that dyslexia 'really gets in the way of achieving' pointing towards the negatives and disadvantages of being dyslexia within academia</u></p> <p>Further comments that in both academic work and practice, some have seemed to have adapted or it's not so bad</p> <p><u>This adds to earlier comment that some adapt, or it's not too bad, further extending her knowledge to the variability of dyslexia</u></p> <p>Reiterating her understanding of dyslexia on commenting on the variability of dyslexia from mild to severe</p>	<p>Affects people differently</p> <p>Can get in the way of them achieving</p> <p>Vary in severity from mild to quiet severe</p>
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<p>severe... or not severe something would be,</p> <p>...but usually you've not seen that, and so you go on what the student says, if the student says, 'Oh, I'm really bad' we think, 'Crikey, they must be really bad if they're telling you they're bad' but others will say that it's..., you know, that it doesn't affect them too much. And that they can manage their difficulties. So basically, you go by what the student says, which is VERY approximate, isn't it?</p> <p><b>Mentor 1A:</b> If you've read their report, their assessment, then you're..., <b>you're not in the dark, then you've got a little bit more insight.....I think it gives you a little bit more basis for what you might expect from your student, or what they might need, but I think that a lot of the time we're working in the dark</b></p> <p><b>Mentor 1A:</b> We don't have much evidence for what helps these students. We don't have much understanding of what's severe, what's not severe, how it</p>	<p>Adds further to previous comments about the contents of an assessment, which provides details of intellectual level which gives you more information about the severity of dyslexia</p> <p>However adds on most occasions, she hasn't actually seen that assessment and has to go on what the student tells them</p> <p>Comments if the student says I'm really bad, states, 'they must be really bad if they're telling you they're bad'</p> <p><u>Interesting observation that if the student says they're bad, they must be bad. Very much influenced by what the student tells them about their dyslexia</u></p> <p>Reiterates this further going by the student tells you about their dyslexia makes it very approximate</p> <p>Access to the report gives a clearer insight of what to expect from the student or what they might need,</p>	<p>Rarely see the dyslexia assessment</p> <p>Go by what the student tells me about their dyslexia</p>
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<p><b>presents. And so I think, you know, as a Course Director and academic, you..., you're led by the student really.</b></p> <p>And you just hope that they manage. You hope that they keep passing</p>	<p>but comments a lot of the time we're working in the dark</p> <p><u>Interesting comments from a tutor's perspective of 'a lot of the time we're working in the dark' perhaps demonstrating lesser knowledge of what they're dealing with</u></p> <p>Describes how as tutors they don't have much evidence what helps the students and much understanding of what's severe and what's not severe and again are led by the student</p> <p><u>Reiterates the key issue that the tutors have little information about the student's dyslexia, and are mainly reliant on what the student tells them</u></p> <p><u>Final comment that they hope that they manage and hope they keep passing suggests in this case a tutor has little control on how they might support a student with dyslexia</u></p>	<p>Not much understanding of what's severe and what's not severe</p>
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### 6.3.2.1 Summary of Findings on Understanding of Dyslexia (Tutors)

The understanding amongst the tutors appears for the most part quite detailed and advanced in contrast to the mentor's knowledge of dyslexia. A number of tutors (tutor 1A, 6F) commented on the different categories of dyslexia such as mild, moderate and

severe. Additionally, some commented on the reliance of the student to describe and explain their specific needs (tutor 5E, 1A). One tutor (2B) commented mainly on the literacy difficulty, specifically reading and writing. Tutor 3C mentioned the use of coloured filters to aid reading. Tutor (4D) mentioned the difficulty of following lines across a page. Therefore, there is a variance in knowledge amongst tutors over their understanding of dyslexia. There was not any further questioning to determine a source for the tutors' knowledge, but evidence might suggest their contact with dyslexic nursing students within an academic environment may heighten their awareness of dyslexia and thus their knowledge of it.

#### *6.3.2.2 Summary of Findings on Experiences with a Dyslexic Student (Tutors)*

The experiences of the tutors with a dyslexic student were individually very different. Tutor 1A said that their experience with a dyslexic student had been positive but tricky, but also a 'bit of a battle' referring to another dyslexic student and the understanding that support with a dyslexic student will be different. However, then commented that non-dyslexic students may also have similar difficulties. Tutor 2B spoke of a very positive experience with Holly and had no qualms about her whatsoever. However, she also spoke of another dyslexic student who had great difficulty in practice and stated sometimes there is a fine line between whether the problem is due to dyslexia or not being able to do the job, which reveals a perception of blurring of boundaries between dyslexia in this case and ability. Tutor 3C (Lucy) also spoke of a positive experience with his student and commented that he felt she was very much in tune with her dyslexia and it was not a disability to her. Tutor 4D (Marie) spoke of her surprise when she discovered her student was dyslexic and expressed how shocking the news must have been when she received her diagnosis. Tutor 5E (Olivia) spoke of

a positive experience, commenting on how diligent, hardworking and enthused she was. However, then spoke of other students, dyslexic or not, where it was like 'walking through sludge' to pull them along. Tutor 6F spoke of how generally dyslexic nursing students have developed effective coping strategies and the intuitive and creative side of dyslexia should be embraced by nursing.

These accounts present mixed and varied experiences. Those who spoke of their own students generally spoke of a positive experience, but some identified that non-dyslexics may experience similar difficulties or problems; therefore, presenting perhaps a blurring of boundaries in respect of tutors' perceptions of students with difficulties whether they be dyslexic or not.

#### *6.3.2.3 Summary of Findings of Perceptions of Dyslexia (Tutors)*

The tutors' perceptions presented quite a spectrum of how they perceived dyslexia. Tutor 1A spoke of others' perceptions of dyslexia stating that there is a fear that if you are dyslexic you are more likely to make a mistake in practice or your documentation might not be as professional, and described this as something that some students cannot overcome. Additionally, she spoke of the impact of dyslexia, but also stated they can have the same academic challenges as non-dyslexic students. Tutor 2B commented that there was a tendency to produce a label for dyslexia but this can sometimes be used as an excuse, and compared both dyslexics and non-dyslexics saying some will be more able than others. However, she makes a particularly significant statement, '...start to mix things like labels and dyslexia, it can sometimes provide people with the equal opportunities excuse, of being able to do something, or being allowed to continue further, than they would otherwise'. In contrast, tutor 3C commented that dyslexia should not hold them back. However, she highlighted

situations in clinical practice where they might be required to write a detailed report and might struggle because of their dyslexia, but adds 'it doesn't mean they cannot overcome it'.

Tutor 4D commented that nurses had every right to be in that profession; they should be able to provide care and it is not that it is a physical disability. Tutor 5E described dyslexia as an entity, but it is related to 'a lot of other things', particularly the way their dyslexia affects them and thus described it as complicated. Tutor 6F commented that once the student is suitable to enter our programme, regardless of what disability or illness they might have, we are then all fully duty bound to try and get that student through the programme and support them. These collectively present quite different perceptions, some suggesting an underlying concern about a student with dyslexia, others demonstrating quite paternalistic support. Additionally, a number of the tutors highlighted little difference between dyslexic and non-dyslexic students in terms of difficulty they might experience.

### **6.3.3 Step 3 – Developing Emergent Themes (Tutors)**

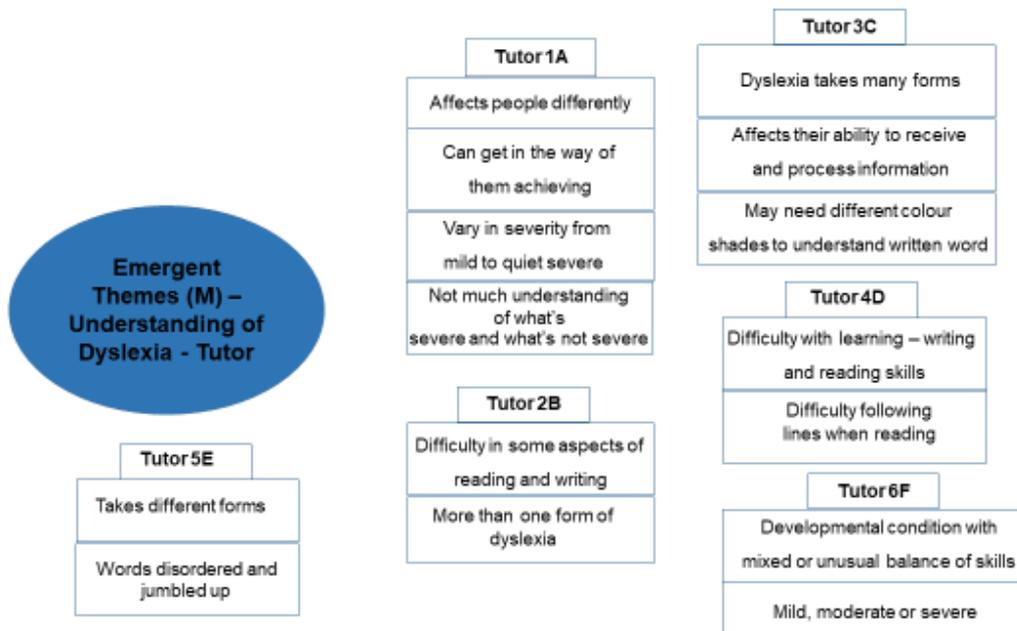
As in the previous case 2 of the mentors in the chapter, the IPA step-by-step process of the analysis of the interview data of the tutors was undertaken in step 2 (initial noting), which is evident by the example tables prior to this section. The initial themes from the tutors' interview data are listed in table 6.10.

**Table 6.10 – Case 4 – tutors’ initial themes (phase 1)**

M – Understanding of dyslexia
N – Personal experiences with a dyslexic student
O – Perceptions of dyslexia

As previously with case 3 (mentors), key themes were identified from the initial noting phase and were formatted into a diagrammatic format to highlight these themes and key statements from the tutor participants were included from each of these themes.

These diagrams are shown in Figures 6.5, 6.6 and 6.7:



**Figure 6.5 – Emergent themes M – understanding of dyslexia, tutor**

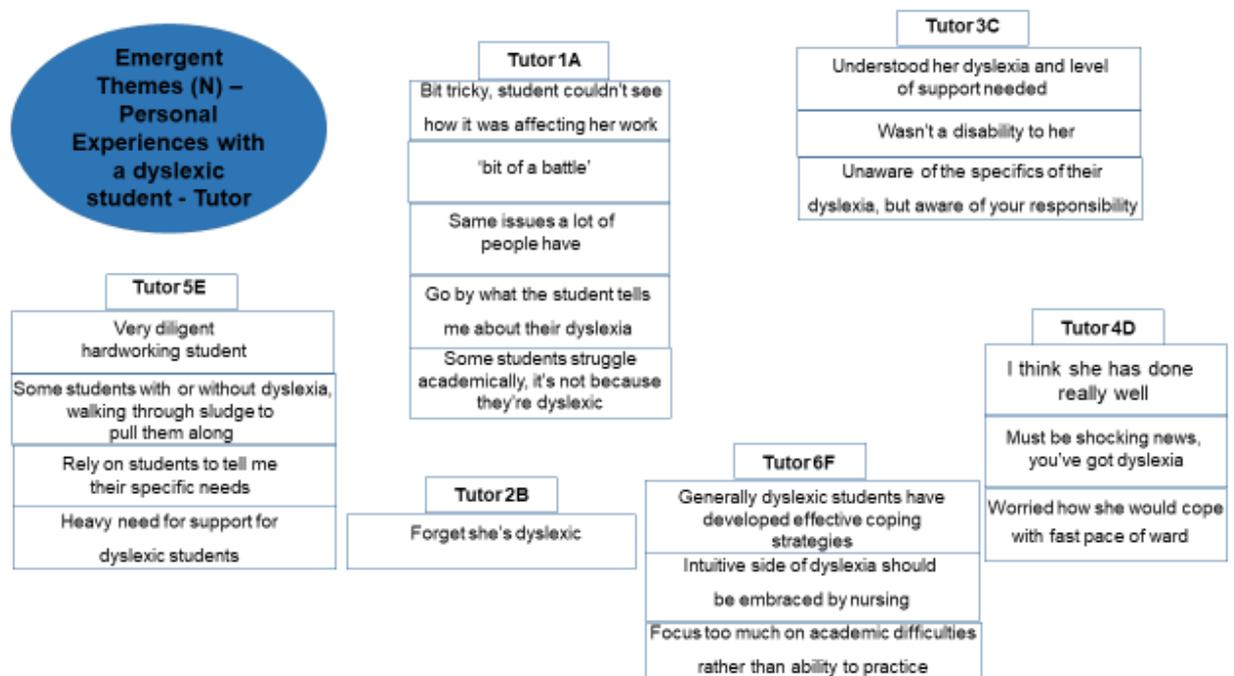


Figure 6.6 – Emergent themes N – personal experiences with a dyslexic student, tutor

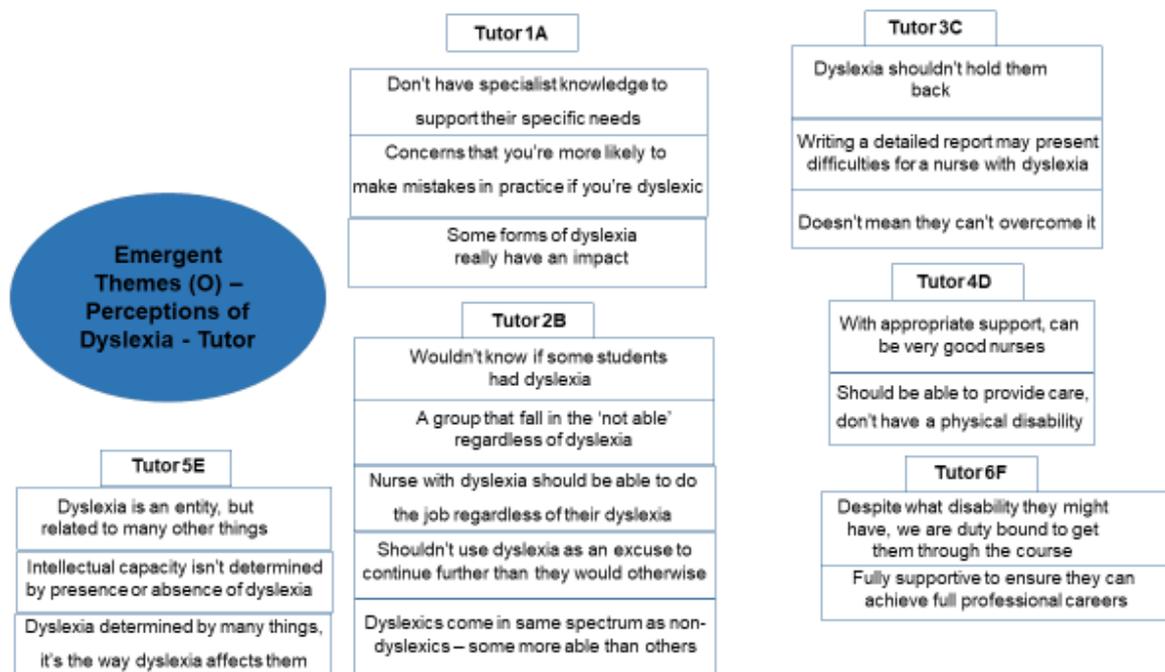


Figure 6.7 – Emergent themes O – perceptions of dyslexia, tutor

### 6.3.4 Step 4: Searching for Connections across Emergent Themes (Tutors)

At first glance, these diagrammatic connections were less apparent than in previous cases. Even though looking for patterns across cases comes later in the process, as I had already looked at a number of cases already, there was an irresistible urge to look for patterns and connections at this earlier point. There seemed fewer connections across themes. What the tutors were saying was far more detailed and often quite profound, which was quite individual to them, so there was little room to connect or contrast tutor statements. Therefore, any connections or similarities were statements of no more than two in number. In light of this, I began to make connections across participant statements, rather than directly across themes. This is apparent in Photo 6.2 where the arrows make connections across individual statements within themes rather than across themes. This allowed common themes to emerge.

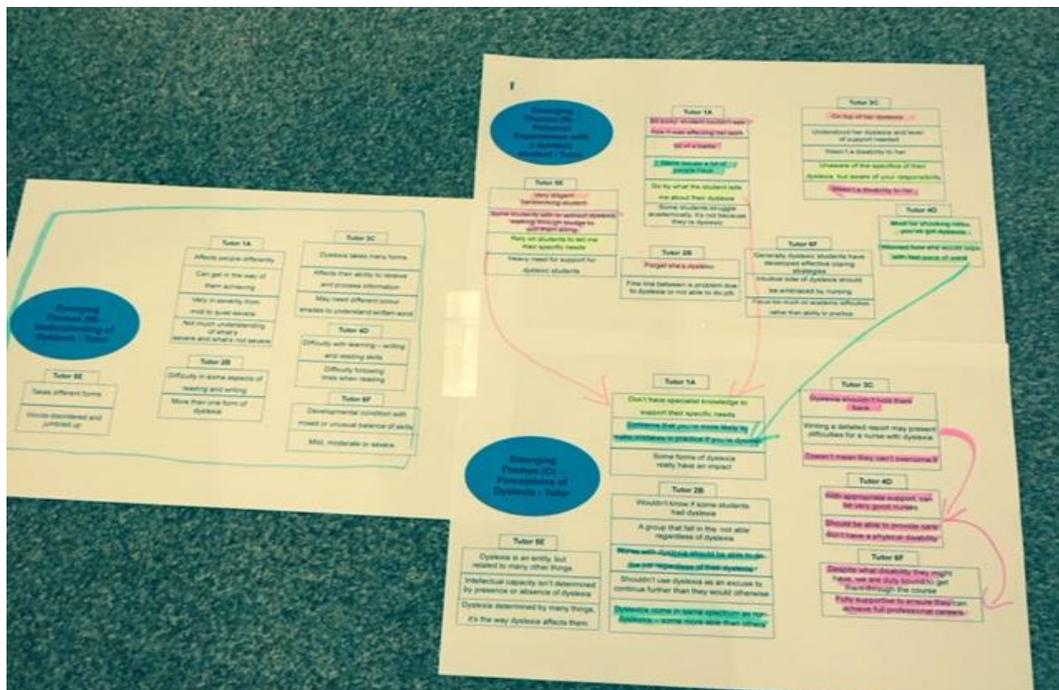


Photo 6.2 Connections across statements within themes – case 4 tutors

In photo 6.2, theme M, 'understanding of dyslexia' is situated to the left, as there appears to be no immediate connection with the other two themes. It is worthy of note that the tutors' responses regarding their understanding of dyslexia were quite detailed and in-depth. It was useful to contrast these against the mentors and preceptors' same responses to their understanding of dyslexia when all cases were cross-referenced to make comparisons.

As previously highlighted, it is important to reiterate that tutor 1A and 6F were not personal tutors to any of the nursing students; rather, they were course directors and not known by the students. Therefore, their responses were from a broader experience of dyslexia in nursing rather than from tutoring an individual student.

A number of common themes began to emerge from both emergent themes. These statements from theme O, 'Perceptions of Dyslexia' revealed a collective supportive approach to students with dyslexia, as well as a perspective that dyslexia should not be a barrier to their practice.

### **1. Supportive approach to students with dyslexia**

- Dyslexia shouldn't hold them back (tutor 3C)
- Doesn't mean they can't overcome it (tutor 3C)
- With appropriate support, can be very good nurses (tutor 4D)
- Should be able to provide care, don't have a physical disability (tutor 4D)
- Despite what disability they might have, we are duty bound to get them through the course (tutor 6F)
- Fully supportive, to ensure they can achieve full professional careers (tutor 6F)

However, in contrast, a further common theme became apparent from themes O and N that of the difficulty supporting a student with dyslexia can bring. However, within this theme there was mention amongst some tutors of similar difficulties with non-dyslexic students.

## **2. Students with dyslexia can cause difficulties for tutors, but similar difficulties to other students**

- Some students with or without dyslexia, walking through sludge to pull them along (tutor 5E)
- Heavy need for support for dyslexic students (tutor 5E)
- Bit tricky, student couldn't see how it was affecting her work, bit of a battle (tutor 1A)
- Dyslexics come in same spectrum as non-dyslexics – some more able than others (tutor 2B)
- Same issues a lot of people have (tutor 1A)
- Some students struggle academically, it's not because they're dyslexic (tutor 1A)
- A group that fall in the not-able regardless of their dyslexia (tutor 2B)

A number of the tutors stated that they relied upon the student telling them what their needs were rather than having an existing knowledge of dyslexia. Again, this was apparent across both themes O and N.

## **3. Reliance upon dyslexic students to tell me of their needs, lack specialist knowledge**

- Rely on students to tell me their specific needs (tutor 5E)

- Go by what the student tells me about their dyslexia (tutor 1A)
- Don't have specialist knowledge to support their specific needs (tutor 1A)
- Unaware of the specifics of their dyslexia, but aware of your responsibility (tutor 3C)

With reference to practice, there were some concerns expressed by some tutors over the ability of a nurse with dyslexia and how they might cope in practice.

#### **4. Concerns over ability to cope in practice**

- Worried how she would cope with fast pace of ward (tutor 4D)
- There are concerns that you're more likely to make a mistake in practice if you're dyslexic (tutor 1A)
- Nurse with dyslexia should be able to do the job regardless of dyslexia (tutor 2B)
- Fine line between is the problem due to dyslexia or not able to do the job (tutor 2B)

As highlighted earlier, with reference to theme M 'Understanding Dyslexia', it was evident that the tutors had a good knowledge and understanding of what dyslexia was.

The following statements provide examples of this knowledge and understanding:

#### **5. Good level of knowledge and understanding of dyslexia**

- Vary in severity from mild to quiet severe, affects people differently (tutor 1A)
- Difficulty in some aspects of reading and writing, more than one form of dyslexia (tutor 2B)
- Dyslexia takes many forms, affects their ability to receive and process information, may need different colour shades to understand written word (tutor 3C)

- Difficulty with learning – writing and reading skills. Difficulty following lines when reading (tutor 4D)
- Takes different forms, words disordered and jumbled up (tutor 5E)
- Developmental condition with mixed or unusual balance of skills, mild, moderate or severe (tutor 6F)

Five common themes emerged from the initial emergent themes from the tutors' data.

### 6.3.5 Step 6 – Looking for Patterns across Cases

As in previous cases, a series of master themes were drawn from each case, which was compared to identify patterns across further cases in a later section. From the process of initially identifying a number of emergent themes, a number of master themes were categorised, as outlined in Table 6.11:

**Table 6.11 – Master themes from case 4, tutors**

Evidence of supportive approach to students with dyslexia
Supporting a dyslexic student can be difficult, but similar difficulties in supporting non-dyslexic students
Reliance upon students to tell tutors of their needs, lack of specialist knowledge
Some concerns over dyslexic nursing students' ability to cope in practice
Evidence of good level of knowledge of dyslexia amongst tutors

## 6.4 Case 5 – Preceptors

The final case of this study comprises the preceptors outlined in phase 2 of the study (Figure 5.2). Preceptors are registered nurses who support a newly registered nurse in their first six months of registration. The preceptors all consented to take part in the

study and were known personally by the registered nurses in the study, as they had acted as their preceptor in clinical practice. Specific characteristics of each preceptor are detailed in Table 4.5 in section 4.3.4 of Chapter 4. One preceptor did not wish to take part in the study, the preceptor to Lucy in the study. Each preceptor is identified by a specific code as outlined in Figure 5.2. These codes are outlined in Table 6.12 as are their respective registered nurses whom they supported through their preceptorship. Preceptor 3C who did not wish to take part is highlighted by a shaded area in Table 6.12:

**Table 6.12 – Registered nurses and preceptors’ connections**

Emma	Preceptor 1A
Holly	Preceptor 2B
Lucy	Preceptor 3C
Marie	Preceptor 4D
Olivia	Preceptor 5E
Chloe	Preceptor 6F

As in all previous cases, following the step-by-step process of IPA, the analytical process of case 5 commences with step 1 – reading and re-reading.

#### **6.4.1 Step 1 – Reading and Re-reading**

All the transcripts of the preceptors were read and re-read and all audio recordings were listened to allow immersion into the data. During this process, notes and observations of particular areas of interest were noted and are summarised in Table 6.13:

**Table 6.13 – Initial notes and observations from preceptor transcripts**

<ol style="list-style-type: none"> <li>1. Limited knowledge about what dyslexia is amongst some preceptors</li> <li>2. Can understand the fear of disclosure, but important to disclose</li> <li>3. Little training or preparation to be a preceptor to a newly registered nurse</li> <li>4. Recognition of a lack of tolerance towards dyslexia</li> <li>5. Perceptions of some preceptors have changed since being a preceptor to a nurse with dyslexia</li> <li>6. Perceptions of some preceptors have not changed since being a preceptor to a nurse with dyslexia</li> <li>7. Overall supportive of nurses with dyslexia</li> </ol>
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**6.4.2 Step 2 – Initial Noting**

As highlighted in previous cases, initial themes can be identified at case level, therefore in respect of this, initial themes were again identified in this case at the initial noting, step 2, and additionally in respect of research question 2, highlighted at the beginning of this chapter. As in all previous cases, initial themes were followed by noting of particular parts of transcripts from each preceptor participant in case 5, relating to each initial theme. An example of one transcript from the interviews with the preceptors is highlighted in Table 6.14. A sample of preceptor transcripts is located in Appendix 5.

**Table 6.14 – Interview with preceptor 2B, experiences of being a preceptor to a nurse with dyslexia (theme Q)**

<u>Interview 1, Preceptor 2B, p. 2-5</u>		

<p><i>BG You were a Preceptor to Holly who is dyslexic, can you tell me something about those experiences with her as a..., as a Preceptor... working alongside her?</i></p> <p><b>Preceptor 2B:</b> She did..., she did tell me that she'd got dyslexia, when we first started, obviously...in the training...</p> <p><i>BG Yeah.</i></p> <p><b>Preceptor 2B:</b> She..., she didn't really disclose too many things, but she just had this little book with her...and she used to write things down, in her way...and if I was like doing some questioning with her...and then she used to write things down in her way...</p> <p><i>BG Yes.</i></p> <p><b>Preceptor 2B:</b> And, if I was like doing some questioning with her, like maybe over medication things... she would just say, 'Can I refer to my little book?' and I was like, 'Yeah, course you can' like, you know... I have no problem with that.</p> <p><i>BG Sure.</i></p>	<p>Commented on how Holly wrote things down in her little book, often a common methods used by dyslexic nurses to remember things</p> <p>Describes how Holly would ask her whether she could refer to her little book when questioned over such things as medication and comments she had no problem with that</p>	<p>Always had notebook to write things down</p> <p>As long as she can do the job, that's all that matters</p>
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<p><b>Preceptor 2B:</b> And..., and that's the only thing really, that I can... remember her doing...she always had this book in her pocket, a little notebook...</p> <p><i>BG Yeah.</i></p> <p><b>Preceptor 2B:</b> And wrote things, obviously, the way she could understand it... and that's fine, because as long as you can do your job...it doesn't really matter...that you can..., that you have to refer to your little book, I..., I've got things that I refer to, so...</p> <p><b>Preceptor 2B:</b> You know, I..., I don't..., I don't have a problem with that, I refer to things when it comes to maths, I can't remember all the maths calculations...</p> <p><i>BG Of course.</i></p> <p><b>Preceptor 2B:</b> So, I get my little book out of my pocket, [<i>Chuckles</i>], does it really matter? As long as you..., you know, you get to the end result... I haven't got a problem with that, I didn't see that as being a problem...with that at all.</p>	<p><u>Use of a little book to check things seen as perfectly acceptable by preceptor 2B, non-dyslexics might use similar as aide memoires</u></p> <p>Comments that she has no problem with the use of a little book to remember things, as long as she can do the job it doesn't really matter, she has also things she refers to</p> <p>Reiterates she doesn't have a problem with this, she gives an example she can't remember maths calculations. She states as long as you get to the end result, she doesn't have a problem with that</p>	
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<p><b><u>Interview 1, Preceptor 2B, p. 5-9</u></b></p> <p><i>BG: What were your first thoughts that went through your mind, when she informed you, or disclosed to you?</i></p> <p><b>Preceptor 2B:</b> Not really, because you have to work with the people...with..., with the.....I don't know the word to use; special needs?</p> <p><i>BG Sure.</i></p> <p><b>Preceptor 2B:</b> Maybe that's it, I..., I don't know, I haven't..., I don't have a problem with that.</p> <p><i>BG Was this the first time you were a preceptor to a nurse with dyslexia, as far as you were aware.</i></p> <p><b>Preceptor 2B:</b> She was my first nurse...</p> <p><i>BG Was she? OK</i></p> <p><b>Preceptor 2B:</b> So, yes, I suppose in a way she was. I have worked with other students...but</p>	<p><u>Makes comparisons with herself over the use of strategies such as notebooks to remember things, so such simple strategies are used by non-dyslexics, which makes it more acceptable if recognised as something she does also</u></p> <p>Comments that you have to work with people with (hesitates) special needs</p> <p><i>Grapples with what word to use, finally using special needs/ almost perhaps detects some stigma connected to the word, special needs</i></p> <p>Clearly states she doesn't have a problem with that</p>	
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<p>not in a nurse..., like me, as a preceptor to nurses...</p> <p><i>BG Sure.</i></p> <p><b>Preceptor 2B:</b> Many years ago, I worked at a college... I worked there 16 years... And I started the NVQ up... I'd got 16 years of disability...awareness anyway, so, I'm quite happy to work with people like that...</p>	<p>States she was her first nurse with dyslexia she supported as a preceptor</p> <p>Comments that she worked in a college for 16 years with students with disabilities, thus has a lot of disability awareness and is happy to work with people with disabilities</p>	
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#### 6.4.2.1 Summary of Knowledge and Understanding of Dyslexia (Preceptors)

The knowledge demonstrated by the preceptors varies from quite limited knowledge to very advanced knowledge of dyslexia. Preceptor 1A described it as people who find reading and writing difficult and can affect their sight in the way they write things down. Preceptor 2B stated it is how you write things down and recalls someone he knew at school who was always getting their 'D's and 'B's back to front, but thinks it is how you express yourself. Additionally, commented that they are worried they cannot spell which might mean people cannot read it. Preceptor 3C admitted she does not know much, but just commented those with dyslexia cannot spell. In contrast, preceptor 5E

demonstrated a more detailed knowledge of dyslexia commenting that people with dyslexia see written forms in a different way, and their concentration levels might not be as high with the need for a quiet area to write otherwise they may get a bit muddled. She stated she picked up this knowledge from different students she has mentored who have dyslexia.

Preceptor 6F described how it can affect student learning and that there are different types of dyslexia. Additionally commented on the different coloured overlays used, which stop the words jumping about on the page and the processing of information can be quite slow and thus affected people cannot read or write quickly. Preceptor 6F also commented that she had previously studied a Post Grad Education certificate where she gained this knowledge. There are similarities amongst the mentors' knowledge of dyslexia with emphasis upon literacy difficulties, particularly reading and writing, perhaps showing the more societal view of dyslexia focusing on literacy difficulties. Two of the preceptors (6F and 5E) in particular demonstrated a more detailed and advanced knowledge of dyslexia.

#### *6.4.2.2 Summary of Experiences of Being a Preceptor to a Nurse with Dyslexia*

The preceptors' experiences of being a preceptor were distinctly different between each participant. Preceptor 1A described how he first discovered Emma was dyslexic when he asked her about her glasses and described how he felt ashamed that he did not know. He also described how he created a grid sheet on brown paper to help Emma remember the patients on the ward, but what was significant was that it was beneficial to other ward nurses, not just Emma. Preceptor 2B described Holly's use of a little book to help her remember things, which as she states, she did not have a problem with, and as long as Holly could do the job, there was not a problem. She also commented

on her previous experiences of working with students with special needs, which she felt had influenced her supportive approach to a nurse with dyslexia.

Preceptor 3C commented that she would not have known Marie was dyslexic as she was doing very well, which tentatively suggests she might consider that if she had dyslexia, she might not expect her to be doing very well. She also commented that on realising Marie had dyslexia she thought she should check she understood what she had told her or repeat it. Preceptor 5E described how Olivia was very open and honest about her dyslexia; however, commented that her first thoughts on realising Olivia was dyslexic were that it might be quite tricky and there may be problems, demonstrating a preconceived notion of dyslexia. She also commented how Olivia found reading the doctors' writing on drug prescriptions difficult and she had to double check with others, but this made her safe. Preceptor 6F spoke of how some dyslexic nurses have not told her of their dyslexia and her emphasis of the need to know such information, simply because they can be supported.

#### *6.4.2.3 Summary of Perceptions of Dyslexia as a Preceptor*

Preceptor 1A described how people with dyslexia just need that extra time and attention, also commented that 'they're not thick, they just have a condition'. He also described the negative attitudes of others towards nurses with dyslexia he had experienced; he did not like people to be derogatory to others. Preceptor 2B spoke of her previous experience of working with students with special needs and how that has greatly influenced her attitudes towards those with disabilities and that anyone who diverges from the normal will be ridiculed. She also commented that you can learn from people with disabilities and what it is about is helping people achieve their goals.

Preceptor 3C described how she did not even know much about dyslexia, so did not even know what to expect from a dyslexic. She further commented that it was a bit like MS, you can have severe or mild and that Marie was a 'mild one'. Preceptor 5E described how she first saw dyslexia as a disability, but now she does not as a result of her experience with Olivia. She felt it does not disable her, which is a significant statement in that her direct experience with Olivia shifted her thoughts surrounding dyslexia as a disability. Preceptor 6F described how she has become more tolerant of dyslexia as she has gained more knowledge of it and commented she has no concerns regarding a nurse with dyslexia whatsoever. What concerns her particularly is if nurses do not tell her they are dyslexic, so she cannot put things in place for them. However, she further commented that disabilities you cannot see, such as dyslexia, can be more difficult. There again remains variability in the perceptions of the preceptors as with the mentors and tutors, which appears at first glance to be influenced by previous experiences as well as knowledge.

#### **6.4.3 Step 3 – Developing Emergent Themes (Preceptors)**

As in previous cases in this study, step 2 involves a closer examination of the initial themes from each case to identify emergent themes. As previously, the initial themes in case 5 (preceptors) were identified from the original interview transcript data and then analysed in greater depth in step 2 of the initial noting. This is evident in Table 6.13 above and further examples can be found in Appendix 5. In the third column of these tables, key themes from the statements or responses of the participants were noted. These were formed into a diagrammatic format from the initial themes listed in table 6.15:

**Table 6.15 – Initial themes from case 5, preceptors**

P – Knowledge and understanding of dyslexia

R – Perception of dyslexia

Q – Experiences of being a preceptor to a nurse with dyslexia

The diagrams for each initial theme are in Figures 6.8, 6.9 and 6.10:

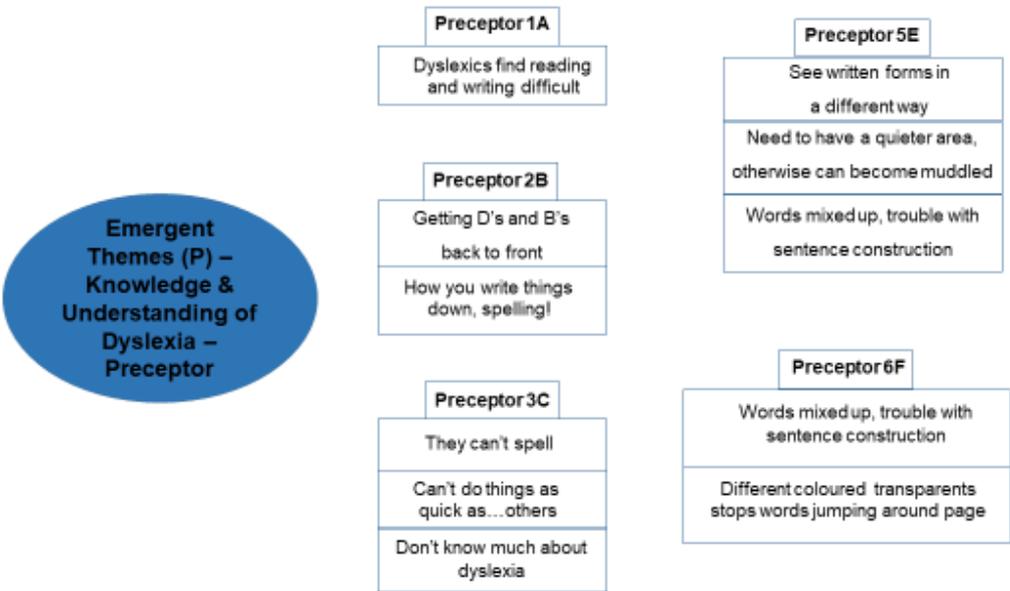


Figure 6.8 – Emergent theme P: knowledge and understanding of dyslexia – preceptor

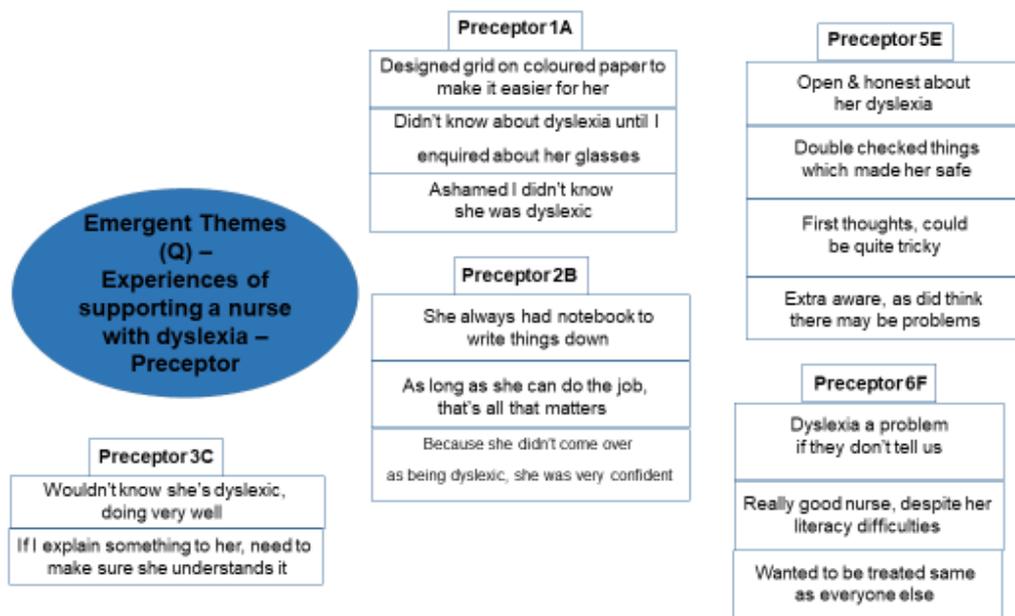


Figure 6.9 – Emergent theme Q: experiences of supporting a nurse with dyslexia, preceptor

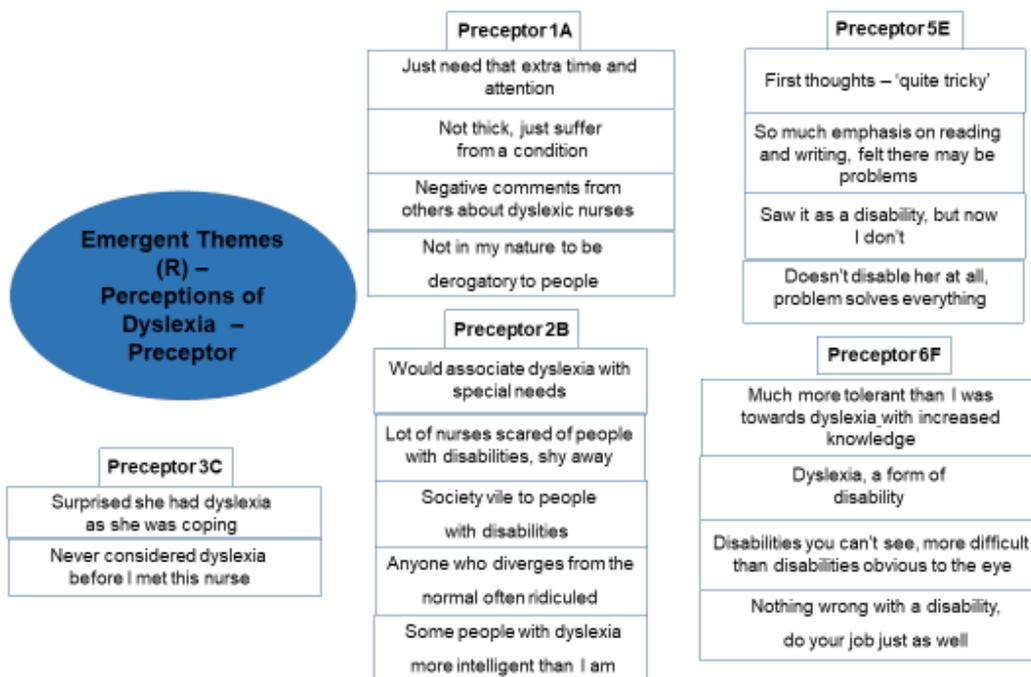


Figure 6.10 – Emergent theme R: perceptions of dyslexia, preceptor

As previously, I examined the statements of the preceptors from the initial theme diagrams, and identified common themes using coloured highlighter pens and began to make connections across those themes. Photo 6.3 shows this process:



Photo 6.3 Connections across statements within themes – case 5 preceptors

This moves the process on to step 4, which begins to make connections across emergent themes.

#### 6.4.4 Step 4 – Searching for Connections across Emergent Themes

As I began to look across these statements, I considered other cases I had previously looked at and noted a number of similarities to other themes in the previous cases.

Firstly, the theme around knowledge and understanding showed an emphasis by some of the preceptors on identifying dyslexia as very much a literacy difficulty, describing it as a difficulty with spelling and reading. Additionally, there was a link between a statement by preceptor 6F that Chloe was a 'really good nurse despite her literacy difficulty' with mentor 2B who said of her student, 'it's a shame because practically she's a really good nurse'. Both these statements claim she is a good nurse despite her dyslexia or difficulties associated with her dyslexia, perhaps suggesting dyslexia is a real threat or hindrance in this context. These specific observations will be explored further in Chapter 7 of the discussion chapter.

A number of common themes from the preceptor data began to emerge as I viewed the key statements and responses across emerging themes Q and R. These are separated below as follows:

#### **Dyslexia not a problem in practice; can still do the job**

Just need that extra time and attention, not thick, just suffer from a condition (Preceptor 1A)

Because she's doing very well, we didn't have any issues to find (Preceptor 3C)

Doesn't disable her at all, problem solves everything (Preceptor 5E)

Nothing wrong with a disability, do your job just as well (Preceptor 6F)

As long as she can do the job, that's all that matters (Preceptor 2B)

#### **Underlying concerns/assumptions about a dyslexic nurse**

Surprised she had dyslexia as she was coping (Preceptor 3C)

First thoughts, could be quite tricky (Preceptor 5E)

Extra aware, as did think there may be problems (Preceptor 5E)

Wouldn't know she's dyslexic, doing very well (Preceptor 3C)

Dyslexia a problem if they don't tell us (Preceptor 6F)

### **Changing views about dyslexia**

Never considered dyslexia before I met this nurse (Preceptor 3C)

Saw it as a disability, but now I don't (Preceptor 5E)

Much more tolerant than I was towards dyslexia with increased knowledge (Preceptor 6F)

### **Differences in knowledge and understanding of dyslexia**

Dyslexics find reading and writing difficult (Preceptor 1A)

Getting 'D's and 'B's back to front, how you write things, spelling (Preceptor 2B)

They can't spell, can't do things as quick as others, don't know much about dyslexia (Preceptor 3C)

See written forms in a different way, words mixed up, trouble with sentence construction (Preceptor 5E)

Words mixed up, trouble with sentence construction, different coloured transparencies stops words jumping around the page (Preceptor 6F)

### **6.4.5 Step 6 – Looking for Patterns across Cases**

As in all previous cases, a series of master themes emerged from this case and a comparison of patterns across further cases will be matched in a later section. From the process of initially identifying a number of emergent themes, a number of master themes can be categorised, which are outlined below:

#### **Master Themes from Case 5 – Preceptors**

1. Dyslexia not a problem in practice, can still do the job
2. Underlying concerns/assumptions about a dyslexic nurse
3. Changing views about dyslexia
4. Differences in knowledge and understanding of dyslexia

As has been described in all previous cases, the last step of IPA is step 6 'looking for patterns across cases'. This section now brings together the final step of IPA where each case is examined across all cases as a whole and identifies any patterns. Therefore, at this stage in the thesis each case has been analysed and interpreted individually; however, in the latter cases, some patterns across some cases have already been alluded to, as I have begun to consider differences or similarities between some cases.

However, this section now collectively and systematically looks across each case as a whole. This aspect of IPA shows stark similarities to a key element of case study research where, as described by Thomas (2011), a case study is looking at a subject from many and varied angles. We can get closer to the 'why' and 'how' and as well as the thing in itself as 'a whole.' Therefore, in respect of this and as this study is a case study, this final step of IPA is looking at the essential elements or parts of the data, namely the cases and looking at them as a whole.

#### **Master Themes from Case 4 – Tutors**

1. Evidence of supportive approach to students with dyslexia
2. Supporting a dyslexic student can be difficult, but similar difficulties in supporting non-dyslexic students
3. Reliance upon students to tell tutors of their needs, lack of specialist knowledge
4. Some concerns over dyslexic nursing students' ability to cope in practice (n2)
5. Evidence of good level of knowledge of dyslexia amongst tutors

#### **Master Themes from Case 3 – Mentors**

1. An understanding amongst mentors of the negative stigma of dyslexia

2. Concerns amongst some mentors (n2) over safety in practice of a nurse with dyslexia
3. No concerns or preconceptions amongst other mentors (n2) about nurses with dyslexia in practice
4. Limited understanding of dyslexia – focus on literacy difficulty
5. No mention of dyslexia on mentoring training courses

### **Master Themes from Case 5 – Preceptors**

1. Dyslexia not a problem in practice, can still do the job
2. Underlying concerns/assumptions about a dyslexic nurse (n3)
3. Changing views about dyslexia (n1)
4. Differences in knowledge and understanding of dyslexia

The three preceding lists present the master themes drawn from the mentor, tutor and preceptor data. There are a number of patterns and similarities that are noted across the three master themes. Firstly two mentors, three preceptors and two tutors expressed some concerns to varying degrees about a nurse with dyslexia in practice. One mentor described a nurse with dyslexia as potentially dangerous, the second mentor expressing concern over giving the wrong drug. However, in contrast the other two mentors expressed no concern; one mentor stating that anyone can make errors. One of the tutors highlighted there are concerns that you are more likely to make a mistake if you are dyslexic, rather than stating a concern herself. The second tutor commented that dyslexia should not be used as an excuse. However, other tutors commented that with good support, they can be very good nurses, another commented

that dyslexia should not hold them back. This presents contrasting views over concerns over the ability of a nurse with dyslexia to practise safely in clinical practice.

Varied knowledge about dyslexia across three sample groups was also noted. Knowledge about dyslexia amongst the tutors was, for the most part, quite advanced and detailed, in terms of identifying specific difficulties. In contrast, the mentors and preceptors had a more simplistic understanding, identifying rudimentary literacy difficulties, such as reading and writing with some admitting to not really knowing much about dyslexia. These differences reflect the differing knowledge base between the tutors and mentors and preceptors. The reasons for these differences are unclear; however, linking to one master theme highlighted from the mentors, all of the mentors stated there had been no mention of disability on the mentor courses they attended. This may allude to why their knowledge of dyslexia was limited in comparison to the tutors.

These themes have been collated in Figure 6.11, which show some commonalities across these three cases. These master themes will be explored and discussed in greater detail making reference to current and past evidence on the areas highlighted in Chapter 7.

# Patterns across Themes - Mentors/Preceptors/Tutors

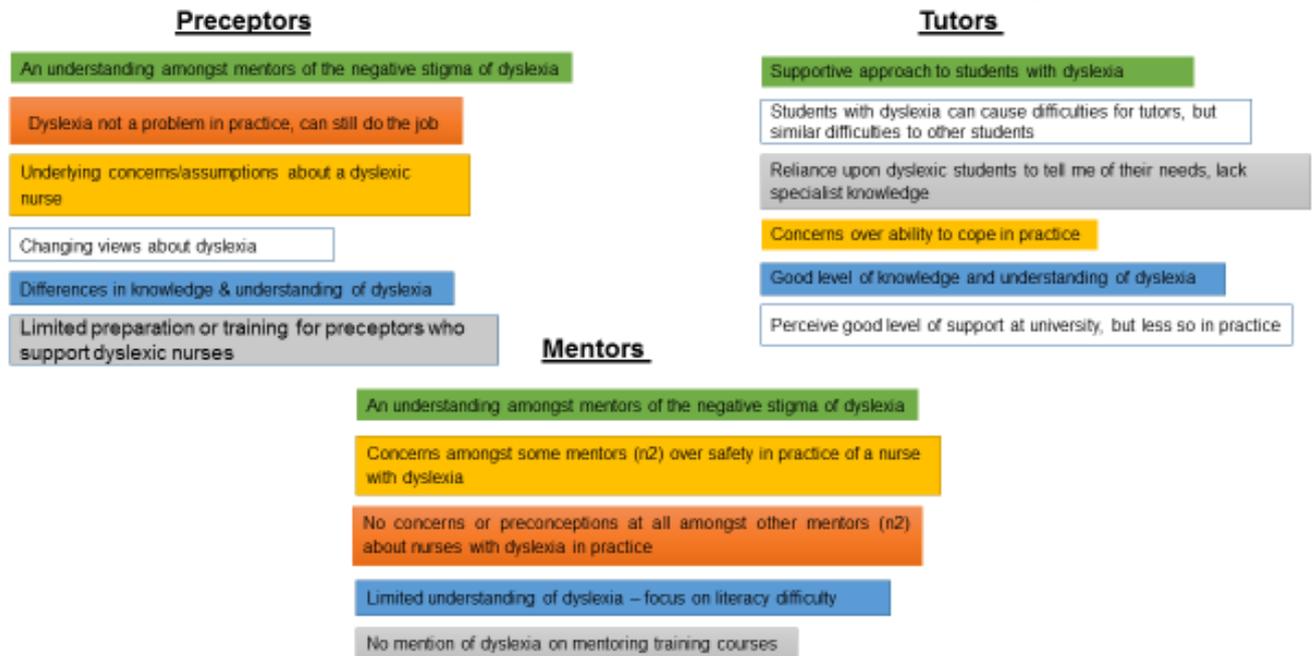


Figure 6.11 – Patterns across themes for mentors, preceptors and tutors

## 6.5 Analysis of NMC Policy Documents

This section of the data analysis now considers research questions 3a and 3b and explores a number of NMC policy documents, which detail the policy of disability within the nursing profession:

**RQ 3a. What is the professional position of the Nursing and Midwifery Council (NMC) surrounding dyslexia in nursing and nurse education?**

**RQ 3b. How is the professional position presented through the Nursing and Midwifery Council's (NMC's) national standards and guidelines?**

The method of document analysis was detailed in the methodology and design chapter, which outlined a method of grounded theory analysis whereby the researcher examines the documents with an interpretative lens and examines concepts within the document that are of theoretical relevance to my research questions.

The NMC was discussed in some detail in section 3.6 of the literature review chapter, specifically its position on disability through its standards and policy documents. A number of changes to the NMC's standards and guidelines on disability have been made over the past six years, including the publication of a number of new and revised documents. Therefore, the NMC's policy on disability has evolved during the duration of my study. Consequently, in respect of the analysis of these documents, I will focus upon current published documents and refer to any previously published standards, guidelines or position statements to present any comparisons or contrasts.

### **6.5.1 Method of Findings**

I began the process of searching for key documents on the NMC website [www.nmc.org.uk](http://www.nmc.org.uk). I was already aware of a key document *Character and health decision-making guidance* (NMC 2015c), which sets out the guidance when considering the health and character of nursing applicants to a pre-registration nursing programme. I purposely identified NMC published documents that considered disability within nursing through the NMC's statutory guidelines. My initial search involved typing in the key word 'disability' into the search box on the NMC website. This resulted in six documents that make direct or indirect reference to guidance on disability within the nursing profession. However, I chose three of these documents, listed below, which make a more direct reference to health and disability within nursing:

1. *Character and health decision-making guidance* (NMC 2015c)
2. *When studying to be a nurse or midwife – Good health, fitness to practise and guidance* (NMC 2016b)
3. *Health and character guidance for approved education institutions (AEIs)* (NMC 2016c)

### **6.5.2 Character and Health Decision-making Guidance (NMC 2015)**

This document published by the NMC supersedes all previous guidance documents on disability, health and character, specifically the *Good health and good character – a guide for educational institutions* (NMC 2010c), published in response to the Equality Act (2010). This is a nine-page document, which encompasses health, character and disability collectively. The document states its use as follows:

....for use by the Registrar and registration appeal panels when considering the character and health of applicants for admission, readmission and renewal (or revalidation) of registration (NMC 2015c: 1)

My first observation of this text is that it makes no direct reference to disability in its introduction, only to health and character. It might be surmised that disability is included within the term 'health'. This inference can be further supported by reference made to disability on page seven of this document where disability is discussed under a subtitle of 'health requirements'. It states the following in section 30 of this document:

Article 9(2) (b) of the NMC Order states that applicants to the register must satisfy the Registrar that they are of sufficiently good health to be capable of safe and effective practice. 22 "Good health" means that the applicant is capable of safe and effective practice either with or without reasonable adjustments. It does not mean the absence of a health condition or disability. (NMC 2015c, 30: 7)

This section of the document states that the register (registered nurse) must satisfy the registrar that they are of sufficiently good health to be capable of safe and effective practice. At this stage, there is no mention of disability, only health. The document then

provides a definition of 'good health' stating that the applicant is capable of safe and effective practice either with or without reasonable adjustment. However, it follows by stating 'it does not mean the absence of a health condition or disability'. This statement is a little confusing and requires further clarification as this document is claiming that good health does not mean the absence of a health condition or disability? Therefore, does good health in the context of this definition mean you may have a health condition or disability despite been in good health?

What is also significant here is the first mention of disability alongside that of health. Disability is a very broad term and would encompass a wide variety of disabilities including long-term health conditions such as diabetes or epilepsy for example; such conditions may be associated with that of health. However, in the context of my own study, dyslexia cannot really be considered a health related condition; rather, it is often described as a learning difficulty. A person with dyslexia, specifically developmental dyslexia, cannot be described as having a health related condition. Therefore, are disability and health being viewed collectively as one in this document?

A further section (34) in this document makes further reference to disability, again placing it alongside health as follows:

We do not assume that the presence of a health condition or a disability alone renders an applicant incapable of safe and effective practice. All applications to join the register where a health condition or disability is disclosed are treated on a case-by-case basis. Decisions are based on the applicant's ability to practise safely and effectively. We do not make decisions on registration based solely on the nature of the health condition or disability, but based on evidence about the management of the health condition or disability so as to ensure safe and effective practice. (NMC 2015, 34: 8)

This section states that the presence of a health condition or a disability does not render the applicant incapable of safe and effective practice, but treated on a case-by-case basis. Here, quite rightly the NMC claims that they do not generalise with regard to a health condition or disability, but consider the applicant individually; therefore not taking a generic approach to the issue of health or disability. Additionally, this statement reflects the equality of treating each applicant individually.

This statement goes on further that any decision is based upon the applicant's ability to practise safely and effectively; decisions are not based on the nature of the health condition or disability but rather on evidence of management of the health condition or disability. There is strong emphasis in this statement on the ability to practise safely and effectively. Clearly it is an important consideration that patients are nursed and treated by safe and effective practitioners and the NMC clearly states that it does not make the assumption that someone with a health condition or disability is incapable of safe and effective practice. However, it might be argued this denial of an assumption comes from society's view of health and, more significantly, disability in terms of an underlying concern around safety and ability.

As stated by Siebers (2006: 174) 'Disability exposes with great force the constraints imposed on bodies by social codes and norms.' Therefore, is there evidence in this statement of how health or disability is constructed within society and in a secondary sense, within an organisation such as the NMC? This is further apparent in section 37 of this document under the subheading 'Guidance on assessing of health for decision makers' as follows:

Consideration will be given to any case that involves a health condition or disability that could affect the ability of the applicant to meet the standards required of

registered nurses and midwives. The relevant consideration for the Registrar is whether an applicant with a health condition or disability is able to manage that condition so as to be capable of safe and effective practice without restriction. (NMC 2015: 174)

This statement supports the previous statement (34), but adds that consideration will be given if a case of an individual with a health condition or disability could actually affect their ability to meet the standards of a registered nurse or midwife. Due consideration will be given and the question of whether an individual is able to manage that health condition or disability and thus be capable of safe and effective practice without restriction needs to be determined. This statement further considers the assumption in section 34 of a health condition or disability rendering an applicant incapable of safe and effective practice, in terms of whether their ability to practise safely and effectively is actually challenged by their health condition or disability. This perhaps suggests a worse-case scenario for the applicant, that their health condition or disability could potentially affect their ability to meet the standards required of a registered nurse.

The term 'decision makers' in the subheading of this section is not specifically defined at this point in the document but is interpreted as organisations such as higher education institutions, hospital or healthcare organisation employers who facilitate nursing students on clinical placement or recruit registered nurses.

Section 38 of this section refers to further information from a GP or occupational health department as follows:

The Registrar, prior to considering an application that discloses a disability or health condition may require further information. This could be a reference from a GP or occupational health department, a medical testing report if drugs or alcohol are a factor and/or a further medical report. (NMC 2015c)

This provides the registrar, in considering an application, to gain further information from a GP or occupational health department about an applicant's health condition or disability and thus their application to practise. However, with reference to my own study, an individual with dyslexia would not require information from a GP or an occupational health department, rather a report from an educational psychologist or a disability department within a university. In referring to these two medical agencies, the question arises, is there too much emphasis upon medical health conditions and disabilities that have medical related characteristics? Not every disability can be considered medically related, including dyslexia.

The following section titled 'Factors to be considered when assessing health' lists factors such as treatment/management of the condition, nature of the condition or disability and time considerations. The following are a sample of these factors.

39.1 – Whether it is a recurring or relapsing condition

40.1 – Date of the diagnosis

41.1 – The treatment and/or management advised for the condition

41.5 – Recent evidence from the applicant regarding the effective management of the condition

The factors I have listed present again a medical focus to the health condition or disability. However, others listed present a lesser medical focus and could apply to a generic and less medically focused disability such as dyslexia

41.3 – Evidence that the applicant has proactively disclosed the condition and/or disability and sought support/treatment

41.5 – Whether the applicant's employers are aware of the condition and the management of it

### **6.5.3 Document Summary**

The *Character and health decision-making guidance* (2015) is for those who recruit nursing students onto pre-registration nursing programmes and employ registered nurses in respect of applicants who have declared a health condition or disability. One of the key observations I make of this document is its dominant focus on medically related health conditions or disabilities. This suggests a focus upon the medical model of disability with its emphasis upon the problem of the person, which could be directly caused by trauma, disease or some other health condition and requires medical care. This is noticeable particularly at the beginning of the document where it is stated that applicants should be of sufficiently good health to practise. The word 'disability' is not mentioned until page seven and then appears from then on, collectively next to 'health condition'. Therefore, this gives an impression that disability and health are to be treated equally in a nursing applicant, whether they have a health condition or disability.

Health conditions can be related to disabilities, particularly conditions such as arthritis, hearing and visual impairments for example. However, many disabilities have no relationship to health; for example, dyslexia, dyspraxia, dyscalculia or Tourette's syndrome. Obviously, there are myriad multiple health conditions and disabilities; it would be impossible to list all in a document such as this. However, there needs to be a clear differentiation between health conditions and disabilities that can be identified,

with medical impairments or poor health having no association whatsoever with disabilities such as dyslexia. This is particularly significant as dyslexia remains one of the highest declared disabilities in nursing and other healthcare professions (Taylor 2003) and it is estimated that 3–10% of the nursing population admit to having dyslexia (Jelly 2014). Therefore, in respect of this, is the NMC conflating health and disability under a purely medical approach rather than differentiating between medically and non-medically orientated disabilities?

#### **6.5.4 When Studying to be a Nurse or Midwife – Good Health, Fitness to Practice and Guidance (NMC 2016b)**

This document follows on from the *Character and health decision-making guidance* (2015) and adds detail around health and disability and entry onto a nursing programme. It begins with an introductory discussion on the importance of good health to practise as a nurse or midwife.

Good health is necessary to practise as a nurse or midwife. Good health means that you must be capable of safe and effective practice without supervision. It does not mean the absence of any disability or health condition. **Many people with disabilities and health conditions are able to practise with or without adjustments to support them.** (NMC 2016b)

This statement matches the statement in the *Character and health decision-making guidance* (2015), but has now added an extra sentence, which is highlighted in bold. This additional comment states that many with disabilities and health conditions are able to practise with or without adjustments to support them. This reflects an admission that many individuals who work in nursing who have either a health condition or disability often practise without any adjustments at all. Perhaps this statement tries to reassure those with a health condition or disability that this should not restrict anyone

applying, in line with the Equality Act (2010) which states it is illegal to discriminate against anyone solely on the grounds of their disability.

The second paragraph of this document is as follows:

If you have a disability or a health condition, **or have pending charges, a conviction or a caution** it will not necessarily prevent you from entering an education programme, from registering as a nurse or midwife, or from continuing your career as a nurse or midwife. (NMC 2016b)

The highlighted part of this statement 'or have pending charges, a conviction or a caution' is at first impression concerning as the question is raised as to why should criminal charges, conviction or caution sit alongside disability and health conditions? Is there any connection or relationship between disability or health conditions and criminal convictions? Obviously, the safety of the public is paramount in the recruitment of appropriate personnel into nursing and healthcare, and this document is concerned with fitness to practise guidance, but the reason for including criminal convictions here is unclear.

The third paragraph of this document provides further details and guidance to applicants who declare a disability and health condition with regard to how they should be assessed:

If you declare a health condition or disability you should be assessed, where appropriate, with support from the occupational health department, a disability services team, adviser or other medical practitioner (NMC 2016).

This detail is absent from the *Character and health decision-making guidance* (NMC 2015) and includes 'disability services team', which is more directed towards someone with a specific disability such as dyslexia. Therefore, there appears to be a greater

disability focus in this section of the document in contrast to the *Character and health decision-making guidance* (NMC 2015) previously highlighted.

This document also refers to students who are already on an existing nursing programme and may develop a health condition or disability:

As a student, you are responsible for informing your approved education institution (AEI) immediately if you develop a health condition or disability that may affect your ability to practise safely and effectively. This is so that your fitness to remain on the programme can be reassessed. You will be required to declare your good health annually during the course of your programme (NMC 2016b).

This is an important addition to this document as many students can develop a health condition or disability whilst at university. Specific to dyslexia, a study of 195 institutes by the National Working Party on Dyslexia in Higher Education (Singleton 1999) highlighted that 43% of the total university population who have dyslexia are identified after their admission to university. Therefore, it is important to highlight the recognition of health conditions and disabilities at the peri-university stage as well as at the admission stage.

This document also outlines the use of fitness to practise panels and states that since 2009 all undergraduate nursing programme providers have been required to have a local fitness to practise panel to consider health or character issues, and to ensure that public protection is maintained. Clearly, this is an important consideration where practice might be compromised as a result of health, character or disability. This is stated in the following statement:

Referral to local fitness to practise panels should only be used if a student's health or disability is likely to compromise or has compromised their ability to meet the required competencies and practice safely without supervision (NMC 2016b).

There is an expectation that such referrals would be assessed on an individual basis; however, this point is not emphasised within this document.

### **6.5.5 Document Summary**

*When studying to be a nurse or midwife – good health, fitness to practise and guidance* (NMC 2016b) outlines the importance of good health in practising as a safe practitioner either as a nurse or midwife, but also outlines how an applicant would seek advice if they have a disability or health condition from different departments or agencies. This element was not in sufficient detail in *the Character and health decision-making guidance* (2015b). However, what is unusual about this document is the inclusion of pending charges, conviction or a caution next to that of health condition and disability, and collectively offers the same advice for any of these in seeking advice about whether you are adequately supported to provide safe and effective practice. It is questioned whether there are any links or relationships between a health condition or disability and criminal convictions or cautions, or that seeking advice should be similar and offering one explanation of placing these together within this document.

Additionally, this document provides guidance for those who develop a health condition or disability whilst on an undergraduate nursing programme. As stated, this can potentially occur, and with specific reference to dyslexia, 43% of the total university population who have dyslexia are not identified until after their admission to university (National Working Party on Dyslexia in Higher Education, Singleton 1999).

The document also provides guidance on the use of local fitness practice panels for students with either a health condition or disability which may be likely to compromise or actually compromise their ability to practise as a safe practitioner. However, this

document fails to outline that such referrals to fitness to practise panels would be assessed on an individual basis, which under the Equality Act (2010) is expected.

#### **6.5.6 Health and Character Guidance for Approved Education Institutions (AEIs) (NMC 2016c)**

This document outlines how it provides guidance to approved education institutions and practice partners and ensures that they have appropriate policies and guidance about a number of statutory requirements surrounding nursing programmes including legal requirements and reasonable adjustments for applicants and students on programmes. This document also provides an online link to the Quality Assurance Framework for nursing and midwifery education and local supervising authorities (NMC 2017), which describes the NMC's regulatory role in maintaining and monitoring quality standards in nurse education institutions.

One significant statement in this document is as follows:

We do not regulate student nurses and midwives. It is for AEIs to assess the character and health of students and prospective students according to their own policies and processes and equality legislation. (NMC 2016c)

What is significant about this statement is that the NMC clearly states that they do not regulate student nurses and midwives; rather, it is the responsibility of AEIs to assess the character and health of students and prospective students according to their own policies and processes, as well as equality legislation. The key issue here is that such policies and procedures may vary from one AEI to another. All must abide equally by equality legislation. However, reasonable adjustments for a specific health condition or disability may depend upon resources, available budget or even attitude of a particular

AEI in granting or refusing a reasonable adjustment. What might be reasonable for one institution might not be reasonable for another.

The document further advises that the registrar located at an AEI in making a decision whether an applicant is capable of safe and effective practice should use the NMC *Character and health decision-making guidance (2015)* as previously discussed.

### **6.5.7 Summary of Document**

This document provides guidance to AEs and practice partners on the statutory requirements surrounding entry to nursing programmes with reference to the health and character of applicants. The significant statement in this document is where the NMC clearly states that it does not regulate student nurses and midwives; rather, it is the responsibility of AEs to assess the character and health of prospective students according to their own policies and procedures. This statement would suggest the NMC handover sole responsibility to AEs to make such decisions referring to the *Character and health decision-making guidance (2015)* for advisory guidance. However, there is a potential risk that such decisions surrounding the health and character of a student would vary from one AE to another according to policies and guidelines.

## **6.6 Chapter Summary**

This chapter has presented an analysis of the transcribed interview data of the mentors, nurse tutors and preceptors categorised as case 3, case 4 and case 5 respectively. Using the systematic step-by-step IPA process of analysis and interpretation, specific sections of the transcribed interview data were analysed, as is evident in the example tables included in this chapter. A selection of these tables are

located in Appendices 1 to 5. Additionally, this chapter has also analysed the contents of three NMC policy documents, which provide guidance and policy for the support and management of nursing students or registrants with a health condition or disability. Through this analytical process, a number of key themes and subsequent master themes have been identified, which will be explored in greater depth in Chapter 7 of the discussion chapter.

## **CHAPTER 7: Discussion**

### **7.1 Introduction**

This chapter follows on from the previous Chapters 5 and 6, following the analysis of the research data from this study. The discussion places the data in a wider context and details specific themes of interest within that data, which goes on to answer the original research questions. As this is a case study, each case will be presented individually initially, with the exception of the nursing students and registered nurses where themes will be contrasted across both cases. These cases have been analysed in detail in Chapters 5 and 6, but presented as an overview below:

**Case 1** – Nursing Students

**Case 2** – Registered Nurses

**Case 3** – Mentors

**Case 4** – Nurse Tutors

**Case 5** – Preceptors

In the discussion of these cases, reference will be made to the existing literature highlighted in Chapter 3 of the literature review chapter. Additionally, new literature will be referred to, where new or unexpected themes have emerged from each case (Smith et al. 2009). Initially each case will be discussed individually and reference will be made to any patterns across emerging themes. Additionally, reference will be made to the Frith framework as detailed in Chapter 2.

In commencing the task of writing the discussion chapter of my thesis, I was conscious of the large amount of data I had amassed during the interview process and during the progression of my study, and thus the multiple themes that had emerged. Therefore, I will take each case individually initially, in the order above, and discuss them using evidence to support this discussion.

## **7.2 Case 1 and Case 2 – Nursing Students/Registered Nurses**

### **7.2.1 Theme 1 – School Experiences**

With reference to the first theme, 'school experiences', I refer back to the Analysis of Research Data, Chapter 5, and to one of the first interview questions asked of the nursing students: 'Tell me about your experiences at school?' This transcends findings from section 5.3.2.2 and Figure 5.4 in Chapter 5. Research question 1a asks the nursing students what they think influences their professional and educational experiences in clinical practice. This research question considers how their school experiences might have provided a background of their development through their early formative years at school, as a person with dyslexia. Out of the six nursing students, only three (Marie, Lucy and Olivia) were diagnosed at school, the other three (Holly, Emma and Chloe) were diagnosed as adults. Wray (2009) noted that some nursing students who had dyslexia received their diagnosis at school, whilst others were not diagnosed until after they had commenced pre-registration nursing programmes. Additionally a further study by Wray et al. (2012) noted that 11% of an undergraduate nursing cohort were formally identified as having a specific learning disability (SpLD) at the end of the first year, compared to 3.9% of students with a declared disability entering the cohort. Many students may not realise that they have a SpLD at school or college and as they move on to university, SpLD may become

evident with the higher academic demands and nature of degree level study (Mortimore and Crozier, 2006; Jamieson and Morgan, 2008; Pavey et al., 2010). Fitzgibbon and O'Connor (2002) described high ability dyslexics, but also some of average ability, who do not exhibit literacy weaknesses during their schooling and are termed 'literacy competent' dyslexics and are least likely to be diagnosed at school. However, there remain experiences of those who are not diagnosed with dyslexia whilst at school who struggle academically and experience feelings of failure and negativity from teachers (Gibson & Kendall 2010).

The school experiences of the six nursing students in this study vary. Emma described her anger that her dyslexia was not picked up at school outlining how well she did in her first and second years, but then in the third year, the teachers were telling her she was not revising. She also commented how she could not understand why she could not get her words onto paper and in her fifth year, she 'totally gave up'. She further described the overall impact of her experiences at school speaking about her dramatic drop in confidence and more significantly, she thought she was stupid. These negative experiences are reportedly not uncommon amongst dyslexics, who were not recognised or receive a diagnosis of dyslexia at school (Lewandowski & Arcangelo 1994; Gibson & Kendall 2010). Additionally, other studies have shown those with dyslexia at school also experience feelings of being different, stupid and inferior (Ingesson 2007). However, a study by Gibson and Kendall (2010), which explored the experiences of dyslexic students in HE who had not received a dyslexia diagnosis at school, described the consequences of not having a 'label' and appropriate support were clear factors in relation to their feelings of failure within the school education system.

Emma's negative school experience was in contrast to that of Lucy who received a diagnosis of dyslexia at age nine. Her experience at school was one of support that she received following her dyslexia diagnosis. Lucy's experience was altogether different to Emma. She received her diagnosis at school and received support immediately following her diagnosis. Her experience could not be described as negative in the same context of Emma's drop in confidence and thinking she was stupid. However, Lucy did speak of initial embarrassment about her dyslexia at one stage. Gerber (2012: 31), with regard to learning disabilities (LD) using the US term to describe SpLD or dyslexia, proposed the mantra for thinking about adults with LD as 'one size does not fit all' because there is a wide array of inter-individual differences. Therefore, the variability of the presentation of dyslexia as well as the experiences amongst adults will present differently.

Lucy speaks of her 'embarrassment of dyslexia for a bit'; perhaps the feeling of being different from the other children might suggest one reason for this, which might link to low self-esteem. Evidence suggests a strong connection between student self-esteem and academic achievement (Rhodes & Nevill 2004; Pollack 2005). This same connection could also be related to Emma with her very negative experience of school and her resultant drop in confidence and feelings of being stupid. Her very vivid description of how her 'confidence just sunk to the floor' perhaps suggests a reflection of this low self-esteem. Burden (2008: 188) argued that in 'a society such as ours where literacy is a highly valued skill, a perceived inability to acquire that skill is highly likely to have a negative effect upon any individual's conception of themselves as competent'.

Lucy described how she found her own strategies to her dyslexia and how she coped with it. This is an interesting description of her feelings at this time as evidence indicates that children with dyslexia at school can experience low self-esteem. Barret and Jones (1994) commented that children with moderate learning difficulties who experience difficulty in academic areas, experience low levels of global low self-esteem. Morgan (1997) also commented that when children fail to keep up at school, their self-esteem drops as they begin to question their academic ability. It could be argued that Lucy's early diagnosis at school and early commencement of support influenced her more positive self-concept of herself. Glazzard (2010) and Madriaga (2007) commented that when pupils are given an early diagnosis of dyslexia they have a reason for the difficulties they experience and as a consequence become more confident in their own abilities. Marie, who received her diagnosis of dyslexia at age 10, described the support she received in quite a positive light claiming that at least she could achieve something with someone helping her and did not really feel left out. Glazzard (2010) described how in his study of a sample of 14 to 15 year olds across two mainstream schools revealed that a diagnosis of dyslexia made the pupils more confident and gave them ownership of the label of dyslexia.

Holly, who only received a diagnosis of dyslexia in the second year as a nursing student also spoke negatively of her time at school. Her description of her school experience provides an insight of someone whose academic performance was affected by her perceptions of going downhill and the lack of interest by the teachers, which appeared to result in her finishing school with no grades. Burke (2002) described the internalisation process the non-traditional student goes through and the resultant effect of a self-perception of an unworthy learner and thinker. Holly further described

her overall experience of school as good from a friends point of view, but not an academic point of view. Perhaps this presents a perception of the unworthy learner and thinker described by Burke (2002). Additionally, this links to the issues around self-esteem described earlier relating to Lucy and Emma.

Olivia received her diagnosis of dyslexia at age nine. She differentiated how she felt about her dyslexia between her time at primary and secondary school. She highlighted an incident of a teacher at primary school who became angry with her because she could not manage her multiplication tables. The teacher who reacted angrily towards Olivia, who it is assumed knew she had dyslexia, appeared to have little or no understanding of the difficulties she was facing because of her dyslexia. In a study by Glazzard (2010), one of the dyslexic pupils commented on an angry reaction from a teacher and felt there was a need for teacher training in dyslexia or at the very least a greater awareness of dyslexia amongst teachers, with one student stating: 'They should definitely be told that dyslexics aren't stupid' (Glazzard 2010: 69). Olivia further commented once at secondary school, she became increasingly frustrated. The source of this frustration appeared to be the extra lessons she was having in relation to her dyslexia, because mainly she was away from friends and described how she hated being different. This frustration or resentment of being different or being marginalised because of dyslexia is a common theme amongst dyslexic school pupils (Hughes & Dawson 1995; McNulty 2003; Ingesson 2007; Glazzard 2010). The quite vivid statement made by Olivia of 'I hate the idea of being different', coupled with having to explain her dyslexia to her peers clearly suggested a significant period during her time at school.

Chloe received a diagnosis of dyslexia in her early 20s after she had commenced the nursing course, but felt she was aware of her difficulty at school and suspected she had dyslexia even then and described how she had difficulty getting information from head to paper. This description is a common difficulty expressed by dyslexics (McLoughlin et al. 2002; Moody 2009). However, Chloe described how if she could verbalise the answer, she would not have the difficulty of having to write in the traditional sense. Mortimore (2008) identified this verbal characteristic that some dyslexics possess as 'verbalisers' and described how many students with dyslexia are marked out by the discrepancy between their verbal dexterity and their literacy skills. Chloe went on to give further description of this difficulty and particularly highlighted here the transition from school pupil to university student in relation to the change in level of academic work. She described the change from being quite a decent student to one she described as 'appalling' and 'just like scraping through'. Clearly, the transition to a university student in the context of the academic demands was difficult for her. Evidence suggests that residual difficulties in adult dyslexics, such as a slow reading speed, phonetic spelling and poor written expression, might affect performance throughout adult life, as well as difficulties within a higher education environment (Riddick, Farmer & Sterling 1997; Cooper 2009).

Chloe described how she felt when she received her diagnosis of dyslexia expressing relief that she was not stupid. Chloe's description of her relief on receiving her diagnosis of dyslexia is reported similarly by many other dyslexics (Ott 1997; Burden 2005; Illingworth 2005). Also her description of not knowing she was not stupid or as she describes 'a bit of an idiot' reflects her own self-perception of her difficulties as well as from a broader perspective of societal norms around literacy, as reading is seen as

highly valued by society (Snowling 2000). The self-perception of feeling stupid is not uncommon amongst dyslexics. Evans (2013), in his study that explored identity construction amongst students in higher education reported a number of his participants felt there was a stigma surrounding dyslexia in society that you must be stupid. McNulty (2003) noted in his study on the life stories of adults with dyslexia that many also felt they were stupid. The Mail online newspaper posted a heading entitled 'Dyslexia is just a middle-class way to hide stupidity' (Camber 2007). Therefore, it is argued does society shape the negative self-perception of dyslexia?

As highlighted at the beginning of this section, three of the students, Lucy, Marie and Olivia received their diagnosis of dyslexia whilst at school. This for the most part appeared to have had a positive impact from the perspective of support and the value of that support. Marie commented that she felt well supported and made her feel she could achieve something. Lucy despite, admitting feeling a 'bit embarrassed' initially, commented that she had her own little strategies and was told by her teachers she was coping with it well. A study by Hellendoorn and Ruijssenaars (2000) interviewed 27 Dutch adults aged 20 to 39, who were diagnosed specifically with dyslexia as children. They found that those with positive school experiences were more accepting of their disability. It could be argued that both Marie and Lucy had for the most part had a positive experience and thus were more accepting of their dyslexia. However, in contrast Olivia, despite her diagnosis at school, spoke of a less positive experience, commenting 'I hate the idea of being different.' Thus, her perception of support at school was the opposite to that of Lucy and Marie. Glazzard (2010) and Madriaga (2007) argued that an early school diagnosis of dyslexia is of benefit to children and claimed that when children receive an early diagnosis of dyslexia, they are given a

reason for the difficulties they experience and as a result, become more confident in their own abilities. Whether this is apparent in the case of Lucy, Marie and Olivia is not immediately apparent; however, their development as adults within nursing will be further explored later in this chapter where the potential influence of an early diagnosis of dyslexia can be considered.

Holly and Chloe received their diagnosis whilst at university following their commencement of the nursing course, with the exception of Emma who received a dyslexia diagnosis prior to this. Their experiences at school were different from that of Lucy, Marie and Olivia in that they received no support at school as they had received no recognition of their dyslexia in relation to their academic difficulties. Each of their experiences was distinctly different. Emma spoke of her anger and frustration over her dyslexia not being picked up at school, her drop in confidence and a feeling of being stupid. Holly spoke of how she did not come out with any grades and felt she just went downhill and the teachers were not really interested in her. Chloe, who suspected she was dyslexic at school but did not receive a diagnosis until university, spoke of her ability to verbalise rather than write things down. None of these experiences share any commonalities; each offers an insight into each individual's own experience of their dyslexia adding support to the highly variable presentation of dyslexia and its individual impact.

These negative self-perceptions expressed by some of the students, might be interpreted as low self-esteem. Rhodes and Nevill (2004) and Pollack (2005) have reported the connection between dyslexia and low self-esteem. In Chapter 3, reference was made to the definition of self-esteem by Marsh and Salveson (1985), as a person's

self-perceptions are formed through experience with and interpretations of one's environment. Chloe, Emma and Holly commented on their own individual negative experiences in relation to their environments and the associated impact; therefore, evidence suggests they might be expressing feelings of low self-esteem. However, a specific self-esteem measuring tool has not been adopted in this study, thus an exact conclusive measurement of self-esteem is beyond the limitations of this study.

In relation to Frith's framework, highlighted in Chapter 2, Frith (1995) spoke of the individual variability of dyslexia in relation to external influences such as age, sex, ability, motivation, personality and social support. With reference to the influence of the environment in the context of the experiences of Marie, Lucy and Olivia who received their dyslexia diagnosis at school, Marie and Lucy spoke for the most part of positive experiences in relation to the support they received. Olivia in contrast spoke of a much less positive experience at school. However, in relation to this observation, Frith (1995) admits directly that 'all other things are not equal in real life'; therefore, there will clearly be 'glitches' in considering data of children with dyslexia within a school environment. Frith (1995) commented on socio-emotional factors that can influence cognitive and behavioural elements of dyslexia, which might point to an influence or reason for less positive experiences and Olivia's feelings about support. However, as my study focuses upon adults rather than children and takes a retrospective look at their school experiences, the question is raised, do such difficulties continue into adulthood and how might these be reflected as an adult?

In summary, the discussion of the school experiences reveals a number of sub-themes that have emerged, namely both positive experiences, for the most part, for Lucy and

Marie who were diagnosed as dyslexic at school, but less so, for Olivia who also received her dyslexia diagnosis at school. Emma, Chloe and Holly, who were diagnosed as adults, had a much less positive experience at school and highlighted their feelings of failure and inadequacies. It should be noted that as my study is a case study, the purpose is not to in any way generalise, but rather present an insight into the cases discussed.

### **7.2.2 Disclosure of Dyslexia in Practice – Nursing Students**

Dyslexia represents the most self-declared disability in HE in the UK (Mortimore & Crozier 2006). However, the disclosing of dyslexia to others can be a fearful prospect for many. Some students may not disclose because of the social stigma associated with dyslexia (Elcock 2014). A number of studies highlighted in Chapter 3 have explored the issue of disclosure of dyslexia amongst nursing students as one part of a larger study surrounding nursing students/nurses with dyslexia and/or disability (Illingworth 2005; Sanderson-Mann & McCandless 2005; Morris & Turnbull 2006, 2007a, 2007b; White 2007; Howlin & Halligan 2011; Ridley 2011; Sanderson-Mann et al. 2012; Evans 2015; Crouch 2017). The reasons for non-disclosure can be complex and a number of elements surrounding disclosure were highlighted amongst nursing students. Evans (2015) explored identity constructions of dyslexia amongst dyslexic nursing students in relation to how open or not open they were with their dyslexic identity, describing three broad categories of embracer, passive engager or resister, which ranged from openly willing to disclose their dyslexia to not willing to disclose it at all. The students in this study, for the most part, disclosed their dyslexia; however, some only disclosed under specific circumstances.

Emma described the reactions of others when she disclosed her dyslexia to others in practice; for the most part, they seemed to understand dyslexia. The reactions she described appear quite positive and non-threatening and Emma commented on the understanding of others about dyslexia. However, in contrast she also presented negative reactions to her disclosure of dyslexia describing how if she meets somebody who does not struggle in any way academically, they do not seem to understand it and perceives her as being of a lower IQ or as she describes 'daft'. Here Emma presents a very different reaction previously discussed and her own self-perception of what she thinks others are thinking of her. Her self-perception of her dyslexia is closely linked to that of disclosure in terms of there being no previous evidence of others telling her she has a low IQ, rather this is what she perceives others are thinking. Morris and Turnbull (2006) highlighted examples of misunderstanding and often misinformed ignorance and even hostility by clinical staff when reacting to a disclosure of dyslexia. Child and Langford (2011) described feelings of isolation amongst nursing students with dyslexia primarily due to a lack of understanding.

Holly does disclose her dyslexia and presents specific reasons, her fears of what others might think of her. This account has similarities to Emma's fears and self-perceptions of others. Holly recounted that there are times when she needs to disclose as she emphasises it is important to be upfront as others may question why is she taking her time or having difficulty. Major (2017) noted in her study, which explored the experiences of registered nurses with dyslexia, the importance of disclosing amongst some of the participants to explain their difficulty in spelling. Holly reiterated the fears she expressed were from her own perceptions, rather than recounting specific incidents of actual questioning from others. Riddick (2000) suggested that a label of

dyslexia can be helpful at a private level to know that the differences experienced are not due to a lack of intelligence. Holly further commented on her own self-perceptions of what others may think of her, such as her abilities are not good enough to be a qualified nurse. Morris and Turnbull (2007a) revealed that dyslexic nurses in their study disclosed to managers and colleagues to explain some of their dyslexic traits and characteristics and thus reduce any potential ridicule or embarrassment.

In contrast, Lucy commented on how the staff personality influences her decision to disclose and if she does not feel comfortable with them, she will not disclose. Illingworth (2005) explored the impact of dyslexia on nurses and healthcare assistants and noted six of the participants disclosed to colleagues, but were selective of whom they told, citing reasons such as approachability and helpfulness. Crouch (2017), in her study exploring nursing students with dyslexia, reported a number of the nursing students commented if they had known their mentor over an extended length of time or being on a placement for an extended period encouraged disclosure of dyslexia.

Olivia gave reasons for not disclosing her dyslexia in that it avoids others looking at her and so highlighting particular difficulties she experiences, such as with aspects of reading or documentation. She further added reluctance amongst many to disclose dyslexia to others is for fear of being marginalised or being seen as 'stupid' or 'thick'. Illingworth (2005), Morris and Turnbull (2006), Sanderson-Mann and McCandless (2006) and Crouch (2017) also highlighted the fear of being judged in a similar negative light, because of dyslexia.

Similarly, Marie also spoke of trying to hide her dyslexia, as she fears others might perceive her as 'not clever'. However, Marie also said she does disclose her dyslexia

in certain circumstances; she described how she felt when she told her mentor she was dyslexic and how understanding she was, as she was also dyslexic herself. It is argued whether working with another person who is also dyslexic results in a mutual understanding of the difficulties faced. Marie adopts the term 'when I came out' when describing the act of disclosing her dyslexia. This has particular significance as the term 'coming out' is often associated with the disclosing of homosexuality or being 'gay'. Therefore, is Marie making the same broad association between the societal weight of the admission of being 'gay' and being dyslexic? Additionally, is Marie connecting the same stigma that is associated between these two very different stigmatised associated elements?

Chloe described how when she discloses her dyslexia, she informs her mentor 'as long as you don't laugh at my spelling'. This reveals perhaps an attempt to lighten the impact of dyslexia by making a joke of it. However, she also described that the disclosure of dyslexia can be influenced by the mentor, particularly 'if they're mean or horrible'. This is similar to Lucy's account of disclosure where the personality of a mentor can influence disclosure (Illingworth 2005; Morris & Turnbull 2006; Madriaga 2007; Crouch 2017).

### **7.2.3 Disclosure – Registered Nurses**

I will now discuss the theme of disclosure from the perspective of case 2 of the registered nurses and make direct comparisons to their disclosure when they were nursing students. As highlighted in Chapter 3, there is limited research that has explored the registered nurse with dyslexia (Morris & Turnbull 2007b; Illingworth 2005; Major 2017).

Emma, as a registered nurse, spoke of the wearing of her tinted glasses, which aids her reading and writing difficulty because of her dyslexia. She described how the presence of these glasses means she has to disclose, as people will inquisitively enquire about her glasses, but also described how this took a lot of courage. Therefore, does the presence of her glasses turn the invisibility of her dyslexia into a visible disability? Brunswick (2012: 137) described the invisibility of dyslexia as 'a "wild card" with short term and long term consequences driven by dynamics that are both situational and contextual', meaning the context of education, employment and community and the endless possible situations where disclosure of dyslexia may be required. Stage and Milne (1996) spoke of dyslexia as unseen by a casual observer. This visibility it is argued affects Emma's disclosure choice as she added she would not disclose if she did not have her glasses. Emma also commented that as she has to disclose, this reduces her worry of what others might be thinking of her. Riddick (2000) commented having a label of dyslexia results in a reason for not being seen as unintelligent by others. This sees a slight change in her experience of disclosure as a student where she was quite fearful of others' reaction. However, she still speaks of being perceived, as she described, 'as the child of the group who needs help', again presenting a negative self-perception of herself, thus the fear of judgment by others remains evident, also apparent in studies by Crouch (2017) and Major (2017).

Holly described how she would disclose if appropriate, particularly to prevent as she described, other nurses 'thinking I'm useless'. Such a strategy to reduce others' negative perceptions is similar to that described by Emma and as described by Riddick (2000), a reason for not being seen as unintelligent by others. This appears to match

her same feelings as a student where she was conscious of what others think of her, thus emphasising the importance of disclosure to explain her difficulties.

Lucy appeared more relaxed about disclosing, stating that it is not important and 'if it came up she would', adding 'they know who I am'. This presents a shift in her experience as a student where she commented on the personality of the mentor influenced disclosure. Now she is a registered nurse, this now seems not to be a concern.

Olivia described how she discloses if she needs help with spelling a word and described that her disclosure of dyslexia in such circumstances appears to be accepted by colleagues, in contrast to their surprise that she cannot spell a particular word. This presents a reason of 'acceptance' by others to disclose her dyslexia in such circumstances. However, she also commented that she would not just introduce herself as 'Hi, I'm dyslexic', rather she only cites specific circumstances where she would disclose. Elcock (2014) stated some students may not disclose because of the social stigma associated with it. In contrast to when she was a student, Olivia made no direct mention as to what others might think of her, but alludes to this in terms of not introducing herself as dyslexic.

Marie commented that she still tends to keep it to herself, but if her preceptor is particularly helpful, she will disclose to them. This mirrors her experience as a student where her mentor was dyslexic herself and understanding, hence why she was happy to disclose. This bears similarities to the findings of Crouch (2017) who highlighted some students cited if they had known a mentor for a long period in placement, this initiated disclosure. However, Marie additionally commented that she does not want

others to treat her differently or be looked down on by others. This perception presents Marie's thoughts of dyslexia as having an impact upon how others see her and a need not to be seen as different, again presenting, in her eyes, a stigmatised view of dyslexia. Major (2017) noted in her findings that a common theme emerged where the nurses did not want to be treated differently.

Chloe described 'unless I have a problem, I don't tend to bring it up'. Additionally, with similarities to Olivia, she stated 'I don't go in a room and say Hi, I'm Chloe, I'm dyslexic; no one needs to know'. This again presents a clear unwillingness to disclose her dyslexia to others. Howlin and Halligan (2011) acknowledge that the decision to disclose this personal information is both a difficult and very personal process. In contrast to when she was a student, where she gave reasons for disclosure such as an understanding mentor and making a joke of having dyslexia, this does not seem so apparent now as a registered nurse.

In summary, there still appears to be reluctance amongst the participants as registered nurses to disclose their dyslexia, with Lucy being the exception to this. Lucy indicated that it was not important and if it came up, she would, indicating an acceptance of her dyslexia. The reluctance of the others appears to show little shift in their reluctance and fear to disclose as nursing students. Disclosure links closely to that of self-perception as a number of the participants spoke of their reasons for non-disclosure, such as a fear that they may be perceived as someone with a low IQ or be looked down upon because of their dyslexia. Self-perception as a theme will be discussed further in section 7.2.9 of this Chapter. This adds to the increasing evidence presented

in this study so far of how the stigma of dyslexia remains apparent in the inner thoughts and self-perceptions of nursing students and later registered nurses.

#### **7.2.4 Drug Administration – Nursing Students**

Three of the nursing students spoke of their need to check and double check or even triple check drugs prior to their administration. This strategy has also been highlighted in a number of studies, which have explored dyslexia amongst nursing students (Morris & Turnbull 2006; Price and Gale 2006; White 2007; Child & Langford 2011; Ridley 2011). These studies highlighted the reasons for this strategy were to ensure safety in giving out drugs as well as the additional fear of making a drug error. Emma, Holly and Lucy all commented on using this strategy of double or triple checking drugs.

In stating a rationale for this constant checking of drugs, Emma, Holly and Lucy all spoke of their real fear of making a drug error, with Emma using the word 'paranoia' in describing her fear of making an error. Holly stated 'I would never ever guess' and Lucy similarly described her risk of making a drug error is reduced due to her strategy of checking drugs and additionally commented on the need to check doctors' writing with somebody else if she was unsure of what it stated. Marie highlighted a difficulty with pronunciation of drug names whilst Olivia commented on difficulty reading written prescriptions. Similar difficulties, specifically pronunciation of drugs were also noted in studies by Morris and Turnbull (2006) and White (2007), which both explored the experiences of nursing students with dyslexia in clinical placement and also noted examples of hypervigilance in double or triple checking drugs amongst dyslexic nursing students. Chloe reported a more unusual difficulty of lining up the boxes on a drug chart when reading a drug chart. A number of visual deficits could cause this. Evans

(2004) commented that a number of visual problems have been identified as correlates of dyslexia.

### **7.2.5 Drug Administration – Registered Nurses**

In contrast, once the students had become registered nurses, the same question was asked with regard to drug administration and dyslexia. Similarities in terms of constant double or triple checking and difficulty with pronunciation were again apparent amongst a number of the registered nurses.

Emma, Holly and Lucy again all commented they continue with the strategy of constantly checking drugs prior to administration. However, it was interesting to note that Olivia now states she over checks everything, describing herself as paranoid, particularly in drug administration, but also documentation. It is of interest that Olivia made no reference to this paranoia of checking drugs as a student. Whether it can be surmised that Olivia feels the sudden increased responsibility as a registered nurse as well as the fear of making an error is not clear. However, she also commented that she double or triple checks because she is worried and concerned and so she 'can sleep at night', demonstrating a very real fear of making an error. She also commented that she did not know whether it was her or her dyslexia, perhaps some attempt here to separate out her own persona and her dyslexia. Gerber et al. (1996) argued that some students may view their dyslexia as an essential part of their identity, describing it as 'reframing'. However, with the wide variable presentation of degrees of dyslexia amongst individuals, this will also present a wide variance of how others will identify themselves with being dyslexic, which as Evans (2013) highlighted can also influence openness and disclosure of their dyslexia.

There is evidence from Illingworth (2005), Morris and Turnbull (2007b) and White (2007) of double checking of drugs amongst registered nurses and nursing students with dyslexia, with 82.2% (n=37) of the sample in Morris and Turnbull's (2007b) study citing patient safety as a reason for doing this. Similarly, Holly, Emma and Lucy also cited their reasons for constant checking as to avoid drug errors and thus compromise patient safety. The government in 2001 set up the National Patient Safety Agency (NPSA), which was responsible for reporting and learning systems with regard to adverse incidents in the NHS; medication errors are obviously a clear remit in improving patient safety (Crouch et al. 2008). Medication errors will occur when either human or system failures affect the prescribing or administration of medicines to patients (Mapp 2012). It is arguable whether the constant double or triple checking of drugs demonstrated by the nurses in this study increasingly reduces the possibility of drug errors.

Chloe commented on a difficulty with drug names, as well as matching boxes across the drug chart, a difficulty she had also mentioned as a nursing student. This can be due to spatial awareness, difficulty reading or scanning across lines, which has been associated with some dyslexics (Vidyasager & Pammer 2010), but also can affect up, down and left to right orientation (Murphy 2008). Emma commented that a normal person could make the same mistake over similar sounding drug names. Similarly, Holly also commented that a non-dyslexic nurse would also double check a doctor's writing. Emma and Holly appear to be comparing their own difficulties against non-dyslexic nurses; this could possibly be interpreted as striving to be seen as more normal in the context of their own dyslexia. White (2007) noted in her study that some students used strategies to get others to view them in a positive light, what Goffman

(1959) described as 'impression management'. Without further evidence and further questioning, it is not entirely conclusive whether this is what Emma and Holly are presenting here. However, it is clear that they are both making comparisons of their own dyslexic difficulties against non-dyslexics.

Marie reveals an interesting and unusual strategy in checking spellings or unfamiliar drugs with the use of 'Google'. This might be viewed as a 'modern twist' as well as embracing the increasing technological age on the checking of drugs a nurse might be unfamiliar with. However, it could be argued the use of policy driven pharmacological publications such as the British National Formulary (BNF) are best recommended to ensure accuracy of prescribed drugs and medication. Crouch (2017) noted in her study of nursing students with dyslexia that a number used the BNF, but also some also used the internet as well as the BNF to check drugs. Olivia also commented that the computer system now adopted in her trust for administering medication is easier to read than hand written prescriptions, which many NHS trusts are now adopting. A study by Schneps et al. (2013) noted that dyslexics read better using e-reader devices in contrast to print on paper. Major (2017) noted in her study, which explored the experiences of registered nurses with dyslexia, that a number of the nurses in her study commented on the benefits of electronic health records allowing them to have structure, spell checking and to identify mistakes more easily.

### **7.2.6 Documentation – Nursing Students**

Documentation or record keeping in nursing is an essential element of nursing care as well as an essential nursing skill. The NMC (2010d: 1) state in their NMC Record Keeping standards document, 'Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not

an optional extra to be fitted in if circumstances allow'. All of the students in the study all expressed degrees of difficulty with documentation, which varied from one individual to another, but also showed a number of similarities. Emma described how 'it's hard to take notes down quickly' and finds difficulty with new words she has not seen before. Holly described how she really has to think about what to write and has to find a quiet area to write. Lucy spoke about how nervous she gets about all the detail and has to write in chunks and keep reading it back to check it is ok.

The difficulty associated with literacy difficulties amongst nursing students with dyslexia has been reported in a number of studies (Sanderson-Mann & McCandless 2005; Morris & Turnbull 2006; White 2007; Ridley 2011; Crouch 2017). These studies noted a number of particular commonalities amongst the students: a need for a quiet area to write, difficulty getting a lot of information written down in a hurry and documentation being described as challenging by some students. Olivia and Chloe spoke of a need to write their documentation on a separate piece of paper first to enable someone else to check it first before transcribing this onto the nursing notes. Marie asks others about specific spellings of words before writing. However, Taylor (2003) argued that nurses who do not have dyslexia might also experience such difficulties. Additionally, two comparable studies, which explored dyslexic and non-dyslexic nursing students (Price & Gale 2006; Sanderson-Mann et al. 2012), both reported difficulties with spelling common across the dyslexic and non-dyslexic samples.

It also became apparent from some of the students who expressed fear and embarrassment about their documentation and their difficulty with aspects of literacy

in relation to what others might think of them. Emma spoke of her embarrassment of other people reading her documentation. Holly spoke of her fear of looking stupid to others, Olivia spoke of her fear of others over her writing and Lucy spoke of a fear of not being able to spell a word and others reading her writing. This fear and embarrassment expressed by the students perhaps reveals evidence of a stigma surrounding dyslexia in the context of a fear of what others are thinking of them, in relation to their literacy difficulty and links to self-perception. Susman (1994) defined stigma as an adverse reaction to the perception of a negative evaluated difference. Stigma and self-perception will be discussed further in section 7.2.9. Others spoke of strategies to support them in their difficulties in documentation. Olivia and Marie commented on writing out first on a separate piece of paper before writing on the main clinical documentation to avoid spelling errors. Holly spoke of a quiet area to help her write. Lucy and Olivia commented on how the frequency and familiarity of seeing words and writing helps. Chloe gets someone to check her documentation first. Each of these strategies described have been reported in previous studies (Morris & Turnbull 2006; Ridley 2007; White 2007; Child & Langford 2011).

Frith (1995) speaks of cognitive performance in terms of poor reading performance in children. In relation to adults, there is no question of their ability to read as none of the participants expressed a specific difficulty in reading; rather, the focus is around pronunciation of technical jargon and drug names as well as spelling. In this study, it is difficult to track the participants' precise difficulties from childhood. However, cognitive difficulties surrounding aspects of literacy remained evident as adults, as noted in a number of the participants in this study.

### **7.2.7 Documentation – Registered Nurses**

In contrast, as registered nurses, some participants continued to report some difficulties with aspects of documentation. Chloe spoke of her difficulty spelling technical 'jargon', Marie spoke of difficulties with spelling. Since they had become registered nurses, a number reported improvements in aspects of their documentation. Lucy commented that 'more complex words are easier now' and Holly said she does not need a quiet area anymore to write. However, in contrast Emma commented she still requires a quiet area to write. This demonstrates that familiarity in a particular task can improve that task. Illingworth (2005) also noted this familiarity of tasks amongst nurses with dyslexia. However, there was still evidence of some anxiety over particular aspects of documentation; Lucy commented there was no one to proof read her work and Marie spoke about being conscious of others reading her writing. Olivia also commented that a senior nurse challenged her over her spelling.

This suggests again that Olivia Lucy and Marie may still feel anxious by the difficulties they face and fearful of the reactions of others. Such anxieties have been highlighted in other studies. (Hellendoorn & Ruijssenaars (2000), in a study of Dutch adults with dyslexia, noted that some were often wary of the reactions of others towards their difficulties. Dale and Taylor (2001), in a study of adult learners and dyslexia, noted a number of participants who felt the wider recognition of dyslexia had settled into a stereotype of dyslexia as 'a spelling problem'. Ingesson (2007) in a study of young adults with dyslexia felt their literacy difficulties had affected their self-esteem. Fitzgibbon and O'Connor (2002) suggested such feelings can have many origins, but in many cases can be traced back to childhood experiences. This links to the previous

discussion in this section in relation to feelings of embarrassment and fear expressed by Emma, Holly, Olivia and Lucy as students.

Other observations noted are strategies adopted by some of the nurses to aid their documentation. Emma spoke of visual cues to help her write and her triggers to help her remember items to include in her documentation. Holly commented on 'blinking out' everything around her and reading through what she has written. The visual cues and triggers Emma described are often aspects of a dyslexic characteristic, particularly visual-spatial ability, which has been noted as a specific enhanced ability amongst some dyslexics (Karolyi et al. 2003). Major (2017) in her study of registered nurses with dyslexia, noted that all the participants in her study commented how distraction affected their writing and concentration. Both Emma and Holly commented they needed more time to complete documentation. This was also apparent in a number of other studies (Sanderson-Mann & McCandless 2005; Morris & Turnbull 2006; White 2007; Crouch 2017; Major 2017).

In summary, some of the difficulties the students experienced with documentation remained with them as registered nurses, such as difficulty with spelling and a need for more time. Some also commented of an increased familiarity with particular words and less need for a quiet space to write and use of particular strategies had resulted in an improvement and development surrounding their skills in documentation. However, there was also evidence of some stigma around documentation (Marie & Olivia), that a number were conscious of others reading their writing.

### **7.2.8 Clinical Handovers – Nursing Students**

Clinical handovers are an essential skill that all nurses must develop in clinical practice. The British Medical Association (BMA) (2004: 7) define clinical handovers as, ‘The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or a permanent basis.’ Croos (2014) reiterated the importance of clinical handovers in relation to safe clinical practice with effective communication at clinical handover being the key to patient safety in nursing.

A number of the students expressed embarrassment about reading aloud in front of others during handover. A number of studies have identified the difficulties nursing students with dyslexia experience with aspects of clinical handover (Sanderson-Mann et al. 2004; Price and Gale 2006; White 2007; Sanderson-Mann et al. 2012; Crouch 2017). Olivia admitted she had purposely avoided handover due to her fear of reading aloud in front of others. Morris and Turnbull (2007a) and Crouch (2017) reported evidence of participants using avoidance as a strategy to reduce embarrassment in front of others, such as avoidance of writing or answering the phone. Fear and embarrassment was prominent amongst a number of the students. Lucy expressed a fear of others watching her and reading others’ handwriting and reading aloud at handovers. Marie also expressed a fear of what others were thinking of her during handover, reading aloud in front of others and checking word meanings before reading out. Similarly, Holly spoke of her embarrassment of what others might think of her and expressed difficulty in the pronunciation of particular words in handover. Chloe expressed a fear of being laughed at during handovers. Emma described the difficulty of keeping up during handover and a feeling of embarrassment. Price and Gale (2006)

revealed that the process of handover for dyslexic students in her study presented significant challenges, with one student stating 'I find it really difficult to keep up'.

Embarrassment and fear was a common theme that emerged with regard to clinical handovers amongst the students. These feelings are also apparent in previous sections concerning documentation and disclosure. There is evidence of innate fear and embarrassment amongst some of the nurses of what others might be thinking of them, this closely links to that of stigma; an adverse reaction to the perception of a negative evaluated difference (Susman 1994). However, it can be argued that non-dyslexic nursing students also have a similar fear of handovers in relation to reading aloud and pronouncing unfamiliar words. Price and Gale (2006) and Sanderson-Mann et al. (2012) carried out studies that compared a dyslexic and non-dyslexic sample of nursing students in practice. In relation to handovers, Price and Gale (2006) noted that some of the key issues for both groups were the understanding of medical and pharmacological jargon, language and abbreviations. Sanderson-Mann et al. (2012) reported amongst the most problematic areas of practice for the dyslexic students were handovers. However, some found handovers easier than others, and noted the difficulties they experienced were no different from those encountered by other students.

### **7.2.9 Clinical Handovers – Registered Nurses**

As registered nurses, a number still expressed embarrassment about the process of handover. Marie described her difficulty with pronunciation of words, particularly drug names or complex surgical procedures, also expressed her fear of handing over to others, expressed similarly as a student. Holly spoke of her embarrassment of

pronunciation of drugs in handover, but additionally commented she now felt more confident in handovers as a registered nurse. Lucy commented that nothing had changed with handovers and that as handovers were all verbal, she used bullet points as an aide memoir.

Morris and Turnbull (2007b) in their study of the impact of dyslexia on the career progression of registered nurses with dyslexia, noted a number of the nurse participants commented on the impact of dyslexia on their ability to communicate verbally, such as in-patient handovers or ward rounds. Illingworth (2005) in their study of the effects of dyslexia on the work of nurses and healthcare assistants noted one participant was not confident about taking notes when someone was speaking, such as in handovers. This was similar to how Emma felt about handovers as a registered nurse, commenting that she found it difficult to keep up and reading out to others made her feel very nervous. Olivia, who avoided handovers as a student described when she had to do a handover for the first time as a registered nurse and feeling 'absolutely awful', and how she had to remind herself to slow down. Chloe described how she 'gets a bit lost' with her handovers, she 'misses bits out' as she admits she is not reading it properly.

There remained evidence of embarrassment amongst some of the nurses, now as registered nurses, particularly in difficulty of pronunciation of words and reading aloud in front of others. However, Holly commented that she felt more confident over handovers and Lucy appeared more comfortable adopting a strategy of the use of bullet points to assist her handing over. Similar to documentation and disclosure, there

remained evidence of a fear of stigma amongst some of the nurses of both fear and embarrassment of what others may be thinking of them.

#### **7.2.10 Self-perception – Nursing Students**

In Chapter 3, there was a review of some of the literature surrounding self-perception, self-esteem and self-concept in relation to dyslexia, outlining the differing meanings of these terms. Burden (2008: 190) stated that the reality is that each term has a distinct meaning, which needs to be taken into account if we are ever going to be able to unravel how people with dyslexia see themselves and how this affects their sense of identity. Self-concept is defined as the sum total of an individual's mental and physical characteristics and his/her evaluation of them (Lawrence 2006: 2). How an individual evaluates the difference between their self-image and ideal image is identified as their self-esteem (Lawrence 2006). Evidence suggests through socio-cultural theory that a person's sense of their self and thus their identity will inevitably be affected by what is valued within their society and culture (Kozulin 1998; Kozulin et al. 2003). In this sense, a person's self-perception or self-image might be viewed as an internal entity, but also can be determined by external influences such as society, culture or more directly, attitudes and views held by people within that society. The value that literacy holds within our society has already been stated in Chapter 3 with Burden (2008) suggesting that literacy is a highly valued skill in society, and thus a perceived inability to acquire that skill is highly likely to have a negative impact upon an individual's conception of themselves.

Throughout this discussion so far, the nurses within some of the themes have referred to their fear of what others might be thinking of them because of the difficulties they experience because of their dyslexia. Those who did not receive a diagnosis of

dyslexia at school spoke of their frustrations, embarrassment and resentment of the difficulties they faced at school, and the later impact and associated feelings of fear of what others might be thinking of them when they became adults with dyslexia (Emma, Holly & Chloe). Additionally, there also was fear expressed amongst some of the nurses in disclosing their dyslexia, both as students and registered nurses. With reference to drug administration, some spoke of a fear of making a drug error and documentation, some spoke of their fear and embarrassment about their writing and of others reading their writing and noting spelling errors. The themes of self-perception emerged from this study as the students spoke about their own thoughts and feelings about being dyslexic.

Emma described how she thought others view her as someone with a lower IQ and her embarrassment of the difference between herself and others. The connection between low intelligence and dyslexia amongst those who have dyslexia has been cited in a number of studies (Blankfield 2001; Morris & Turnbull 2006; Ridley 2011; Evans 2015). Holly commented on her embarrassment about dyslexia and what others might think. As she described, 'you're a little bit thick'. Lucy claimed she thinks that many think 'you can't do a normal day job if you're dyslexic'. Major (2017) identified that the nurses in her study recognised the impact of a diagnosis of dyslexia and how it impacted on their sense of self.

Embarrassment and fear of what others might think become more apparent as the students spoke of their own self-perceptions about their dyslexia. Marie referred back to her thoughts prior to commencing nursing with regard to her self-perception, describing how she did not have the knowledge and just could not do it. What she

describes provides a very strong description of how Marie was feeling inwardly of simply knowing what she was not capable of doing. Chloe, who received her dyslexia diagnosis whilst on the nursing course, speaks of her fear of others thinking she is not clever enough in spelling, specifically more complex drug names. Olivia commented on how others assume you to be 'thick' or a 'bit stupid' and question why are you at university. Olivia later reiterated that no one had ever said this to her, rather these were solely her own perceptions.

There are a number of commonalities amongst these statements made by the participants in this study. Evidence suggests a negative self-perception amongst the students of what others might be thinking of them because of their dyslexia, specifically thinking they have a low IQ, thinking they are 'thick' or 'stupid'. As noted on further questioning, no one participant appears to have been told this by others, rather this appears to be purely their own self-perception of themselves. Boetsch et al. (1996) commented that dyslexia can impact on perceptions of intellectual ability and academic competence in adulthood. There appears to be limited research surrounding self-perception of children with dyslexia (Humphrey & Mullins 2002) and less surrounding self-perception and adult dyslexics. Riddick (1996) interviewed 22 children with dyslexia and found that they felt 'disappointed, frustrated, ashamed, fed up, sad, depressed, angry and embarrassed by their difficulties'. However, more recent research has reinforced the link between dyslexia and negative school experiences and the impact upon self-concept, self-esteem and resilience amongst trainee teachers (Glazzard and Dale 2012). Evidence might suggest when examining the accounts of the school experiences of the students in this study that this anger and embarrassment expressed by some may continue into adulthood. Burden (2008) also supports there

is clearly strong evidence for a relationship between dyslexia and having a low academic self-concept. From this perspective, it is very difficult to pinpoint distinct reasons or causation for the self-perceptions expressed from the participants' accounts in this study, rather this provides an interesting insight into each individuals own inner self-perception of themselves, but also adds further evidence for a connection between dyslexia and low self-perception and low self-esteem.

### **7.2.11 Self-perception – Registered Nurses**

The same theme of self-perception emerged when the participants were interviewed as registered nurses. Emma described how everybody thinks she is 'the weak link in the chain' and described her worry of what people think of her. She also described how she feels trapped in her dyslexia. In comparison to her description as a student, her negative self-perception as a nurse with dyslexic remains. As a student, she commented how she perceives others think she has a low IQ and the embarrassment of the difference between herself and others. Emma's innate fear appears to be what others think of her and makes a significant statement describing how she feels trapped in her dyslexia, presenting dyslexia in an almost physical context that is holding her back and preventing her from progressing. Major and O'Brien (2005) described an identity threat model, which consists of situational cues conveying a risk of being devalued and collective representations, namely knowledge of cultural stereotypes that influence the appraisal of threat to one's well-being. In this context, Emma, in her description of what others think of her appears to present a feeling of low self-worth and to a degree, a feeling of being devalued.

Holly, as a registered nurse, described how you can easily 'get bogged down in your dyslexia', particularly in thoughts that 'I won't be able to do this or do that'. She went

onto describe how 'you can let it take over your whole life, but you shouldn't do that'. Holly appears to be taking quite a retrospective view of her dyslexia and is now conscious of the personal impact of dyslexia. She further described that you should not treat it as something to be ashamed of. As a student, Holly commented on the embarrassment of dyslexia and that people might think you are a bit thick. In comparison to her self-perception as a student, her thoughts about dyslexia have changed. Even though she considers the embarrassment surrounding dyslexia, she has now become quite reflective.

Lucy, as a registered nurse, in speaking about her dyslexia stated, 'I'm open to it, it doesn't bother me anymore.' This presents a more open attitude and approach to her dyslexia. As a student, Lucy stated 'I think, a lot of people think that you can't do a normal day job if you're dyslexic'. There appears to be no indication of such thoughts from Lucy as a registered nurse; therefore, like Holly, there appears to be a shift in her thoughts about her dyslexia. Rowlands et al. (2013) illustrated that familiarity with a specific learning difficulty (SpLD) can lead to a student's full acceptance of the diagnosis.

Olivia, as a registered nurse, commented in relation to errors, 'I don't want it ever to come back to me and say oh, it's because she's dyslexic', presenting an inner self-perception of concern over an error she may make being blamed directly on her dyslexia. As a student, she spoke of an assumption by others of being 'thick' or 'a bit stupid'. Olivia does not speak in the same tones as when she was a student with dyslexia, rather her main fears now appear to be around an error that she might make

being blamed on her dyslexia. This suggests she still perhaps perceives her dyslexia as a stigma.

Marie, as a registered nurse, spoke of her concerns that as a nurse with dyslexia, others may feel she is a burden to them. Previously as a student, she spoke of her thoughts that she could not do nursing as she felt nurses were clever and she was not. These two discussions are quite different; as a student she spoke of her thoughts before entering nursing of not being clever enough; however, as a registered nurse she now speaks of her thoughts of being a burden to others. Similarly, with other participants in this study, she perceives a stigma surrounding dyslexia through her own self-perception, but across a timespan prior to entering nursing and as a nurse.

Chloe, as a registered nurse described how being a nurse with dyslexia is just one more thing that makes you stand out as not normal and one more thing that makes you not fit into the fold. As a student, she described how people 'don't think I'm clever enough to be in that role and I'm so scared that they're all going to think I'm an idiot'. Her dyslexia, both as a student and registered nurse, clearly impact her in terms of how she perceives that others are thinking negatively of her.

In comparing the self-perceptions of the nursing students who later became registered nurses, the discussion of evidence of a stigma surrounding dyslexia amongst a number of the nurses is apparent. This is particularly evident throughout the dialogue with expression of feelings of fear, of others thinking of them in a negative light. For example, Olivia spoke of her fears of others thinking she was thick or stupid and Chloe's description of dyslexia just being one more thing that makes you stand out as not normal. As has previously been highlighted, Crocker et al. (1998: 505) proposed

that stigma is not located entirely within the stigmatised person; rather, it occurs within the social context and is a 'devaluing social identity'. This has similarities to Goffman's (1963) view that stigma occurs as a discrepancy between 'virtual social identity', that is how a person is characterised by society and their actual social identity. This returns to the social constructionism previously described in Chapter 4 where how humans make sense of and construct the world around them (Crotty 1998) is described.

Almeida (2012: 90) defined self-stigma as 'an internal process whereby people judge themselves based on messages received from societal norms'. Therefore, are the negative self-perceptions or self-stigma described by the nurses in this study shaped and influenced by society's stigmatised view of dyslexia? Kane and Gooding (2009) argued that people with disabilities are viewed through an established impairment lens. However, it is worth noting that not every nurse in this study spoke of a negative self-perception. This was particularly apparent from Lucy and Holly's words as registered nurses, where Lucy spoke of how 'it doesn't bother me anymore and I'm open to it now'; also, Holly described how 'you shouldn't let dyslexia take over your whole life' and that 'you shouldn't be ashamed of it'. There appears to be a shift in their own self-perceptions of their own dyslexia. The self-perception of dyslexia can be described as a dyslexia identity and the terms can be used interchangeably. Caldas-Coulthard and Fernandes-Alves (2008) claimed that identities are constructed discursively and potentially can be altered in talk and interaction (Taylor & Littleton 2006).

In this context, I returned to the transcripts and looked again at Lucy and Holly's responses. Lucy spoke of how supportive all the staff she worked with were and also spoke of the difficulties she had writing detailed reports, but her manager informed her

she was also dyslexic and it can take years to write such detailed reports properly. It might be suggested from this evidence, that the supportive nature of the staff and her manager being dyslexic altered her dyslexic identity or self-perception. In Holly's case, she described dyslexia as 'a disability, but, not to treat it as something to be ashamed of, rather treat it as a condition that you've got, but you can learn to sort of work with it'. She also commented that she thinks there are many more people out there that are more understanding than she thought there would be; again this evidence may suggest a reason for the alteration in her dyslexic identity or self-perception. A lack of understanding about dyslexia amongst those who support nurses with dyslexia in practice has been noted by many studies (Morris & Turnbull 2007a, 2006; Murphy 2008; Price & Gale 2006; Evans 2013). However, there are also many positive experiences of support cited by nursing students and nurses with dyslexia (Morris & Turnbull 2007b; White 2007; Ridley 2011).

Therefore, evidence suggests self-perception of dyslexia in these cases is an individualised reality, but potentially can be shaped by societal norms of the emphasis upon literacy, which can create a self-stigma of how others might see them. However, it can be seen in the case of Lucy and Holly how this stigma and thus dyslexia identity can be altered over a particular timespan in this case from transition from a nursing student to a registered nurse. Additionally, in consideration of Lucy, Marie and Olivia who were all diagnosed at school, and in noting their experiences as adults with dyslexia, each had a differing outlook and experience. Lucy was more accepting of her dyslexia as an adult, whereas Olivia and Marie still felt somewhat stigmatised by having dyslexia. It is argued by Hellendoorn and Ruijssenaars (2000) that those who had more positive experiences in their elementary school period were more likely to accept their

dyslexia as part of life. However, other studies (McNulty 2003) have identified low self-esteem amongst some adults who received their diagnosis as children.

### **7.2.12 Changes since becoming a Registered Nurse**

Research question 1b of this study asked the nurses in this study if anything had changed as they adapted to working as a registered nurse. The transitional experience from nursing student to registered nurse can be a stressful experience. Krammer (1974) in a US study, used the term 'reality shock' experienced by newly qualified graduate nurses when they experience specific work settings where they felt inadequately prepared. A number of UK studies also identified 'reality stress' amongst newly qualified nurses associated with the student/registered nurse transition process (Vaughan 1980; Walker 1986; Humphries 1987; Lathlean 1987; Gerrish 1990). Gerrish (2000) acknowledged that the transition from student to qualified nurse can be fraught with difficulty as the nurse begins to adapt to the new responsibilities and expectations such a role can bring. Therefore, this section considers the findings of this study in relation to the changes the participants experienced on becoming a newly registered nurse with dyslexia. The previous sections, which have considered and discussed the differences between nursing student and registered nurse, such as disclosure, documentation, drug administration and self-perception, will be now be collectively discussed as individual narratives in relation to changes the nurses experienced since becoming a registered nurse.

Emma, in describing her experience as a newly registered nurse, described how the support system she had at university had been 'whipped away' and further described how she feels that nobody seems to understand her needs as a dyslexic. This perhaps presents a feeling of isolation as well as a feeling of significant change in her

professional life between being a nursing student at university and now a registered nurse in practice. With regard to disclosure, because of the tinted glasses she wears, she stated she has to disclose, but if she did not wear them, she would not disclose, because she feels so conscious of her dyslexia. In discussing drug administration, she spoke of the first time administering drugs on her own, describing the experience as 'petrifying' and 'scary'. With reference to documentation, Emma spoke of a system using A to E as a visual pattern on her documentation to help her with aspects of writing her nursing notes. She also commented that she still needs more time to write and a quiet area and she is often the last to leave the shift, because of the extra time she takes over writing up her documentation. She also commented on new documentation she has to constantly read to enable her to familiarise herself with it. With reference to clinical handovers, Emma commented that she finds it difficult to keep up in handovers and process what has been said. Additionally, in giving handovers, she described her fear of reading aloud in front of others and her difficulty and embarrassment in pronouncing particular medications. In describing her self-perception, Emma described a feeling of being 'trapped in her dyslexia' and her fear of everyone thinking she is the 'weak link in the chain'.

Holly commented that she has grown in confidence and has become familiar with the routine, which has made it much less stressful. She further commented that her dyslexia has taken 'a bit of a back burner, now I'm a trained nurse, it's behind me; it's not a big issue anymore'. This is in contrast to Emma's fear of what others may be thinking of her. However, Holly commented that she will only disclose if she has to and only when appropriate, but will disclose to explain reasons for being slower or as she described, 'to avoid being seen as useless'. With regard to drug administration, Holly

described that they are not really a problem and she has formed a coping mechanism and commented that she will still check and re-check, but this is something she automatically does. With regard to documentation, Holly described that she no longer has to retreat to a quiet area to write, but can blank out any distractions around her, but admits writing documentation still takes her longer than others. With reference to clinical handovers, Holly commented that they have not been a problem, but she still has to double check. Like Emma, she stated that she gets embarrassed over pronunciation of some drug names. Holly described an 'invisible helping hand' when commenting on how she has become more familiar with the ward routine and how the ward runs.

When questioned about any changes since becoming a registered nurse, Lucy made a very clear comment that nothing has changed and it is still the same. When commenting on the disclosure of her dyslexia, she said 'they know who I am and people know I'm dyslexic'. Additionally, when describing her own self-perception of her dyslexia, she commented that she was 'not embarrassed by it anymore, it's part of me'. Lucy appeared much more accepting of her dyslexia and added, 'it doesn't bother me'. This is in complete contrast to Emma, who still feels 'trapped in her dyslexia'. With reference to drug administration, Lucy described how she always double checks the spelling of drugs on the prescription sheet, as the doctors' writing does not always look the same. With regard to documentation, Lucy stated that she probably writes in more detail, as she is conscious of something coming back to her about what she has written, but she stated she is now becoming more familiar with more complex words. With reference to clinical handovers, Lucy commented that she has 'always been all right to

do handovers' and as they are all verbal, this is better. She additionally described the use of bullet points, which makes it easier to remember key points.

Marie described how she finds it more challenging as a newly registered nurse and with similar comments to Emma, described how the support she had at university is now no longer there and there is no longer help for her needs as a nurse with dyslexia. She went on to describe there is now a greater reliance upon herself to read more and use computers to check on specific resources and information. Marie further commented that she feels she is going to be a burden to others because of her dyslexia. In describing drug administration, Marie commented on ensuring she checks the drug before administration and will write down drugs she is unfamiliar with. She additionally commented on the use of a BNF or Google to check some drugs she may be unfamiliar with. With reference to documentation, Marie described how she is conscious of others reading her writing, but places emphasis on how important nursing documentation is in terms of spelling everything correctly; this is something that has stayed with her since university. With regard to disclosure, Marie commented that she would rather keep it to herself, but added if she does come across a mentor who is helping her, she would disclose. Marie describes how before giving a clinical handover, she has to practice about 10 times and how scared she gets if a particular sister is there, as 'she rolls her eyes' when Marie hands over.

Olivia comments are similar to Lucy in that nothing has really changed since becoming a registered nurse with regard to her dyslexia. However, she added that the NHS trust where she now works takes a different approach to previous larger trusts where she worked as a nursing student and rather she feels they seem to be more accepting of

someone with dyslexia. She further described how others are alright about her dyslexia and have no worries or concerns, but added she does not want anyone to think she has made an error because of her dyslexia; she does not want anyone to perceive her dyslexia as an excuse for something she might have done wrong. With regard to disclosure, Olivia stated she will only disclose if she has to, but if she needs to ask someone to help her spell a word, she would disclose in such circumstances. However, she stated that wearing her tinted glasses is one way of explaining it without saying 'Yeah I'm dyslexic'. With reference to drug administration, Olivia described how she has 'never been so paranoid in her life' and experienced some difficulty in reading doctors' writing, and as result was very slow at doing drugs. Olivia commented with regard to documentation that she was becoming more familiar with aspects of documentation, but described how she has been challenged, particularly over her difficulty with spelling; hence, she is very conscious of others reading her writing. With reference to clinical handovers, as a nursing student Olivia admitted she purposely avoided handovers. As a registered nurse, she now has no choice and described the first time she did a handover as a newly registered nurse was 'absolutely awful'. She described the experience as 'making her stomach drop' and has to remind herself to slow down. Olivia described how she has become more familiar with her work through repetition of words, medical conditions and returning patients.

On becoming a newly registered nurse, Chloe commented that it has been a bit easier as there is, as she describes, 'nobody looking over my shoulder'. This is a comment that reveals the difficulty she felt she experienced as a nursing student with dyslexia, but now this difficulty as a registered nurse, in her eyes, is much less and views her current status as under much less scrutiny. With reference to disclosing her dyslexia,

Chloe commented that no one really needs to know, and would only disclose if she had a problem. With reference to drug administration, Chloe commented on the same difficulties she experienced as a nursing student, matching the lines and boxes across the drug chart and added she also has difficulty with similar sounding drug names. In commenting on her documentation, she described how she has difficulty spelling 'technical jargon' and added her handwriting is often illegible. In clinical handovers, Chloe described how she often gets a bit lost and misses things out, but can go back to these when others ask her about particular aspects of patient care. Regarding Chloe's own self-perception of her dyslexia, she described her dyslexia as just another thing that 'stands you out as not normal' or 'not fitting into the fold', again similar to Emma presenting quite a negative self-perception of her dyslexia. Chloe described how she has become more familiar with aspects of her work and as a result is doing things faster. However, she added 'just got more used to the struggle'.

These narratives of each nurse's individual experiences as a newly registered nurse present some very different experiences in terms of their own perceptions and the difficulties some of them still face. There are also some commonalities: Holly and Lucy appear more accepting of their dyslexia as well as evidence of compensatory strategies, such as continued double or triple checking of drugs and taking more time over documentation. As previously highlighted in Chapter 1 and Chapter 3, there is limited research surrounding registered nurses with dyslexia. Three key studies, Illingworth (2005), Morris and Turnbull (2007b) and Major (2017) explored dyslexia amongst registered nurses and a number of similarities were noted in the findings comparable to my study. Each of these studies spoke of the personal and professional impact upon dyslexic nurses in practice. Illingworth (2005) revealed that the nurse

participants in her study feared the stigmatisation associated with dyslexia, which affected disclosure, nurses with dyslexia would spend more time writing their documentation and there was evidence of the dyslexic nurses double checking drugs prior to administration. Morris and Turnbull (2007b) highlighted evidence of a reluctance to disclose for fear of ridicule, job loss or victimisation as well as limited support from managers. Major (2017) highlighted the difficulties experienced by nurses with their spelling and general literacy skills, as well as a reluctance to disclose because of a fear of stigma and being judged. The findings of these studies are consistent with the findings of studies that have explored nursing students with dyslexia in terms of the difficulties experienced, compensatory strategies used and fear of disclosure amongst some (Sanderson-Mann and McCandless 2005; Morris and Turnbull 2006; White 2007; Child and Langford 2011; Ridley 2011).

What my study contributes to this area of research is that, to date, no study has explored the transition from a nursing student with dyslexia to a registered nurse. However, a number of studies have explored the generic transition from nursing student to registered nurse (Holland 1999; Gerrish 2000; Newton & McKenna 2007; Higgins et al. 2010; Kaihlanen et al. 2013). These studies collectively identified that the transition from student to registered nurse is a difficult one and is often not clearly defined in terms of the individual impact such a transition can bring. Newton and McKenna (2007) referred to Krammer's (1974) description of 'reality shock', a state that can be experienced by newly qualified nurses when faced by a new clinical situation where they feel unprepared. Holland (1999) argued that the expectations of student nurses to use their ability to articulate their learning into accountable practice

on qualification does not take into account the complexities the new role of a newly registered nurse brings.

More recently, Kaihlanen (2013) emphasised the significance of the clinical mentor role in the transition process from student to registered nurse. Collectively, these studies all indicate the transition from student to a registered nurse is a difficult one. Similarly, the findings of my study, in relation to the aspect of change from a student to a registered nurse, also indicate some anxieties and fears amongst the nurses with dyslexia. It is argued, in relation to the significant evidence presented highlighting the difficulties associated with this transitional journey, to what degree are the anxieties and fears associated with dyslexia or more simply with the transition from student to registered nurse? However, the aims of my study were not to make comparisons with a non-dyslexic nurse sample; therefore, it is not possible to make definitive comparisons across such samples.

However, Price and Gale (2006) explored the impact of clinical placements on a group of non-dyslexic and dyslexic nursing students and noted a number of generic issues common to both groups. These were difficulty in the understanding of medical and pharmacological jargon, abbreviations and language, and variability of the quality of mentorship, indicating dyslexic and non-dyslexic nursing students can experience similar difficulties in practice, but the limitations to this study is that this is a singular study on one site with two small student samples (n10 – dyslexic, n10 – non-dyslexic). A further study, Sanderson-Mann et al. (2012), also explored the impact of dyslexia on placement based learning on dyslexic nursing students and compared these with non-dyslexic students (n54 – dyslexic, n52 – non-dyslexic) across one site. Their main

finding suggested that students, irrespective of whether they have dyslexia or not, find drug calculations and handovers of a similar ease or difficulty but differ in their ease of use of care plans and patient notes.

A study by Crouch (2011) explored the needs of a sample of dyslexic and non-dyslexic nursing and midwifery students (n15 – non-dyslexic, n7 – dyslexic). One of the key findings was that both groups experienced difficulty with writing, but the dyslexic students reported more academic problems than the non-dyslexic group. Therefore, these three studies suggest similar difficulties amongst dyslexic and non-dyslexic nursing students and with just three known comparable studies, it can be surmised there remains a gap in this area of research. This suggests a need to undertake further comparable research involving larger samples of dyslexic nursing students/registered nurses and non-dyslexic nursing students/registered nurses to determine any such differences.

Chapter 2 presented a discussion on the defining of dyslexia, and discussed and analysed a number of definitions; a definition by Rose (2009:9) was presented as an operational definition:

Dyslexia is a learning difficulty that primarily affects the skills involved in accurate and fluent word reading and spelling. Characteristic features of dyslexia are difficulties in phonological awareness, verbal memory and verbal processing speed. Dyslexia occurs across the range of intellectual abilities. It is best thought of as a continuum, not a distinct category, and there are no clear cut-off points.

This definition identifies specific literacy difficulties experienced by those with dyslexia, but also highlights how it is characterised by difficulties such as verbal memory and verbal processing speed. In relation to the variable experiences described by the nurses in this study and in the context of this definition, it has been identified in this

chapter that the difficulties they spoke of included a number of differing literacy difficulties, including difficulties with spellings, pronunciation of words and information processing. Additionally, the nurses also spoke of their own self-perception of themselves with dyslexia and the impact of this self-perception upon their disclosure of dyslexia to others. The nurses had also developed a number of different compensatory strategies to enable them to cope with these difficulties, such as double or triple checking of drugs, writing notes on separate pieces of paper first or using notebooks or other methods of aide memoire to help them remember. The findings indicated some of the differences between the nurses in this study, supporting to some degree what Rose (2009) alludes to in his definition of dyslexia as a continuum, rather than a distinct category, and further contributes to the evidence of the variable presentation of dyslexia. These findings do, for the most part, meet the description presented in the definition of literacy difficulties and also the compensatory strategies or different ways of doing things, as well as well as a need to take more time over areas of practice,

In Chapter 2, I also discussed the wide variability of dyslexia between individuals with dyslexia referring to Rose (2009) who spoke of co-occurring difficulties such as aspects of language, motor co-ordination, mental calculation, concentration and personal organisation, making the point these are not by themselves markers of dyslexia, but these difficulties can occur as part of a dyslexic pattern. These co-occurring difficulties or characteristics do present the person with dyslexia as an individual whose presentation will significantly vary. Exploring the characteristics of each nurse in this study, despite the presence of commonalities in terms of the difficulties or compensatory strategies they adopt, each individual is distinctly different. Therefore,

the importance of an operational definition of dyslexia remains of value for identifying dyslexia for educational psychologists and teachers. However, the co-occurring difficulties described by Rose (2009), adds to the belief of the wide variability of dyslexia from person to person and supports the agreement that the problems experienced by dyslexic people extend beyond literacy skills (McLoughlin et al. 2002). In Chapter 1, I outlined the contention that surrounds dyslexia and the different views and opinions that continue to be present in the dyslexia debate. Pavey et al. (2010) described how these ongoing debates are partly as a result of different discourses within dyslexia, both psychological and sociological. Despite these differing views and opinions, the differing presentations from each nurse participant in this study provide an insight into how differing patterns of difficulty or co-occurring difficulties present dyslexia as an individual entity.

### **7.3 Case 3 – Mentors**

This section details discussion of the interview data from Case 3 – the mentors. Each theme transcends the findings from Chapter 6. Four mentors were interviewed as part of this study and four main themes emerged from the data as follows: understanding of dyslexia, perception of a nurse with dyslexia and disclosure.

#### **7.3.1 Understanding of Dyslexia**

The first interview question to the mentors was to determine their general understanding of dyslexia. The question simply asked the mentors how they would describe dyslexia. What became apparent from the mentors' responses was that their understanding focused more upon the literacy difficulties of dyslexia, such as struggling with reading and writing, and mixing up or scrambling of words. As has been

highlighted in previous chapters, there is great emphasis placed upon the influence and power of literacy within society (Snowling 2000; Burden 2008). Additionally, Stanovich (1991) argued of an insistence upon utilising intelligence in definitions of reading disabilities such as dyslexia.

Previous studies have identified a lack of understanding of dyslexia amongst some nurse mentors (Morris & Turnbull 2006; White 2007; Child & Langford 2011; Ridley 2011). These studies highlighted that this lack of understanding by mentors left the students with a feeling of inadequate support. Madriaga (2007) commented it is widely reported there is a lack of popular understanding about dyslexia. A study by Sanderson-Mann et al. (2012), which explored the impact of placement learning on a sample of dyslexic and non-dyslexic nursing students, revealed that mentors who had mentored dyslexic nursing students had some understanding of the issues of stigma about dyslexia and disability legislation, but knowledge about living with dyslexia was limited.

It is questioned whether a lack of understanding about dyslexia may develop into negative attitudes towards nursing students with dyslexia? Wright and Eathorne (2003) argued that the NHS has a moral responsibility to anticipate the needs of disabled students. However, more recently the Equality Act (2010) ensures there is a statutory requirement that no employees and students with a disability are discriminated against. A study by Vickerman and Blundell (2010) exploring the needs of disabled students in HE, established that good experiences for students will largely depend on the attitudes, experience and personal knowledge of particular members of staff, rather than institutional policies and provision, and these varied greatly between academic

departments within institutions. Hargreaves et al. (2014) found that 68% of health professionals who worked in the NHS felt they did not know enough about disability. One of the nurses in my study, Emma in her discussion on the disclosure of dyslexia, commented that those nurses who do not struggle academically, do not seem to understand dyslexia at all. Illingworth (2005), in her study of the effects of dyslexia on nurses and health care assistants, revealed that participants' self-esteem was threatened when colleagues behaved insensitively or did not know the best way to help.

The mentors in this study were further asked whether there was any mention of dyslexia on the mentoring courses they had attended, which is a standard for all nurse mentors working in clinical practice (NMC 2015a). All four mentors replied there had not been. This questions whether a lack of inclusion of dyslexia and disabilities in such courses influences the limited understanding of dyslexia and disability amongst mentors. Elliot (2010) highlighted that little education and training in equality and diversity is included in qualifying or post-qualifying NHS education. Black et al. (2011) evaluated the use of a tool to teach students on a mentorship programme about SpLDs; as a result, 61 mentorship students showed an increased knowledge and receptiveness to learning more about dyslexia.

### **7.3.2 Self-perception of Dyslexia**

The mentors were asked to give their own perception of dyslexia; the mentors' responses were contrastingly quite different. Mentor 1A stated that it was about the 'ability to do the job with or without a disability' and commented about getting things the wrong way round himself, suggesting dyslexia was not really an issue to him. He also revealed his own disability, which was not dyslexia, during the interview,

suggesting a greater understanding of working alongside another person with a disability might influence your own disability perception. Wright (2000) identified that support on clinical placement was good because the mentor either was dyslexic or knew someone who was dyslexic.

Mentor 3C described how he had no real preconceptions about it and that it did not concern him; rather, he would ask himself how he could best support them, presenting quite an open and supportive attitude to dyslexia. A supportive approach to students with dyslexia by mentors has been reported in a number of studies (Child & Langford 2011; Ridley 2011). There is limited research that has specifically explored the attitudes and understandings of nurse mentors about dyslexia. Rather, the evidence that is available is provided second hand from the voices of dyslexic nursing students, through studies that have explored the experiences of nursing students with dyslexia (Sanderson-Mann and McCandless 2005; Morris & Turnbull 2006; White 2007; Ridley 2011; Crouch 2017). In contrast to mentors 1A and 3C, mentors 2B and 4D expressed their concerns about a nursing student with dyslexia, mentor 4D commenting 'my main worry would be giving the wrong drug'. The focus on her concern was safety of the patient; however, Wright (2000) Morris and Turnbull (2006) and Ridley (2011) stated there is currently no empirical evidence to indicate a nurse with dyslexia is unsafe in practice. Mentor 3C spoke of such concerns in stronger terms, commenting that a nursing student with dyslexia 'could be potentially dangerous'. She further commented that it was not just a '...problem for her, but the patient she's looking after' and 'if they're not dealing with it, then it's a problem', suggesting the nursing student has a responsibility to deal with her dyslexia without elaborating further on how they should deal with it.

However, it is argued whether a negative perception of dyslexia such as has been described would impact on the disclosure of dyslexia by students as well as self-esteem. Morris and Turnbull (2006) spoke of how the nursing student's reaction when hearing negative comments from others about dyslexia influenced disclosure, also noted by White (2007). Additionally, a number of studies have highlighted nursing students with dyslexia have a greater awareness of safety and use a number of compensatory strategies to avoid error (Morris & Turnbull 2006; White 2007; Ridley 2011; Crouch 2017). However, concerns are still raised by practice providers about the inclusion of disabled professionals, including those with dyslexia (Evans 2014; McPheat 2014; Nolan et al. 2015).

### **7.3.3 Personal Experiences of Mentors**

Further questioning revealed the individual experiences of the mentors with the nursing students in this study. Mentors 1A and 3C spoke positively about the experience of their student, mentor 1A commenting 'self-supportive, best student I've had' and adding 'not prejudiced to any kind of disability'. Similarly, mentor 3C commented that it 'didn't impinge on anything she did'. He further added; 'had some difficulty with writing....helped me understand more about dyslexia'. Therefore, the experience of both mentors with their students was positive and in mentor 3C's experience, this provided him with a greater understanding of dyslexia. A number of studies have highlighted the benefits of positive mentor support for nursing students with dyslexia, which enhanced the student experience (Ridley 2011; McPheat 2014; Crouch 2017).

In contrast, mentor 2A commented particularly negatively about her nursing student. She described an incident where she had asked the student for some written work the student had undertaken earlier that day. On checking the documentation the student

had written and not being aware at that stage she was dyslexic, she commented, 'well you're either stupid or you're dyslexic'. This was a surprising response, which clearly demonstrated a lack of understanding about dyslexia. A number of studies have reported negative attitudes towards nursing students with dyslexia (Morris and Turnbull 2006; Ridley 2011; Evans 2014). The word 'stupid' has been used alongside dyslexia in a comparative way, thus surmising that mentor 2A appears to be making a direct connection between intelligence and dyslexia. It is argued whether this is viewing dyslexia from a 'medical model' perspective. Barnes and Mercer (2010) defined the medical model as locating impairments within the individual, thus placing the responsibility on them to adapt and fit in with mainstream society. Mentor 2A also commented that her first thought was that 'she's in the wrong job' and was surprised she was pursuing nursing, adding to this comment: 'it's a shame, because practically she's a really good nurse'. This is a rather contradictory statement, questioning her ability to be a nurse because of her dyslexia, but at the same time commenting that 'practically she's a really good nurse', perhaps referring to her practical skills in contrast to her writing or reading skills. Mentor 4D commented that she did not know her student was dyslexic until halfway into the placement and added 'I would have kept an extra eye on her if I knew she was dyslexic', suggesting she sensed caution or a potential safety risk from a student with dyslexia. White (2007) described how colleagues on a clinical placement behaved differently after becoming aware a nursing student was dyslexic.

Additionally, these comments made by mentor 2A and 4D could be viewed as discourses. Discourse is a multi-complex linguistic and language discipline. The language spoken about dyslexia offers a further analytical examination about how

people perceive and understand dyslexia, whether that be positive or negative and adds to the overall study of the personal impact of dyslexia. However, Hargreaves et al. (2014) argued that access to healthcare for disabled people remains a challenge. This is despite the legislative requirements of the Equality Act (2010). Sapey et al. (2004) and French (2004) suggested that disabled people continue to face barriers to qualifying as health professionals. The comments expressed by the mentors 2A and 4D might be interpreted as barriers, but also justifiable concerns about patient safety.

Howlin et al. (2014) commented that a number of factors have heightened concern regarding the need to support nursing and midwifery students with a disability in clinical practice. This is coupled with the need to meet the legislative requirements of disability and equality legislation, an increasing number of students with a disability, as well as the need for students to meet professional requirements on professional healthcare courses (Kane and Gooding 2009; Storr et al. 2011; Hargreaves et al. 2014). Nolan et al. (2015) conducted a study aimed at identifying the issues and concerns of practice educators (PEs) in both supporting HE healthcare students with disabilities and exploring the concerns for students with disabilities on professional courses. The findings of this study revealed that a number of PEs expressed concern over the safety and competence of a healthcare student with a disability, specifically safety of the patient, appropriate support and the emergence of a health issue when a disability had not been disclosed. Therefore, the concerns expressed by the two mentors in this study are not unique in the support of healthcare students with disabilities.

#### **7.3.4 Disclosure**

The mentors were asked whether they understood why a student might be unwilling to disclose their dyslexia. Mentors 1A and 3C expressed their understanding of reasons

for non-disclosure, specifically identifying stigma as a reason. Mentor 1A commented there is 'always fear of stigma and labelling' and worry of what people are going to think of them. Mentor 3C commented, 'generally dyslexia can be seen as a reflection of your intellect' and they 'may be seen by others as stupid, ignorant or lazy'. These responses indicate an understanding of the stigma associated with dyslexia. Sanderson-Mann et al.'s study (2012), which explored the impact of placement learning on a sample of dyslexic and non-dyslexic nursing students, revealed that mentors who had mentored dyslexic nursing students before had some understanding of the issues of stigma about dyslexia and disability legislation. Nursing students in a study by Evans (2014), refer to 'being stupid' as a link to their dyslexic identify.

Other studies have highlighted that many nursing students are unwilling to disclose their dyslexia for fear of stigma and negativity by others (Morris & Turnbull 2006, 2007a; White 2007; Ridley 2011; Howlin et al. 2014). In contrast, mentor 2B commented that they may be judged by others, but added it '...should be at the forefront of their mind' and 'because of their job, they need to tell their mentor', emphasising the importance of disclosure in a clinical setting. Some nursing students have prioritised patient safety as a reason for disclosure (Price and Gale 2006; Morris & Turnbull 2006, 2007a; Ridley 2011; Evans 2013). Mentor 4D commented that 'embarrassment... [is as a] reason for non-disclosure', but also added students should 'be open with it, don't cover it up...nothing to be ashamed of'. Again, this is similar to the other mentors' understandings of reasons why students might not wish to disclose dyslexia, but adding that it was nothing to be ashamed of.

However, many nursing students with dyslexia fear the feeling of being different. Evans (2014) discussed the social dimension in relation to dyslexia as an association of being different amongst students with dyslexia. Morris and Turnbull (2007a) who collectively explored the topic of disclosure amongst nursing students with dyslexia noted a patronising attitude or lack of insight amongst mentors as one reason for non-disclosure. In contrast, 'disclosure was seen as a mechanism for telling people about their disability in order to get the "right support" and as a way of encouraging awareness and understanding' (Nolan et al. 2014: 498). Failure to disclose or delays in disclosure are associated with an inability to provide support (Storr et al. 2011). Andre and Manson (2004) and Rankin et al. (2010) maintained that in order for disclosure to occur, there needs to be an environment of trust, openness and honesty. However, Nolan et al (2015) noted in their study that the biggest obstacles to disclosure the students described were negative attitudes and stigma. A number of the nurses in this study cited both stigma and negative attitudes as reasons not to disclose their dyslexia (section 7.2.2, 7.2.3)

## **7.4 Case 4 – Nurse Tutors**

This section discusses the interview data from the nurse tutors in this study. Each theme transcends the findings from Chapter 6. Six nurse tutors were interviewed as part of this study and three main themes emerged from the data as follows: understanding of dyslexia, personal experiences and perceptions.

### **7.4.1 Understanding of Dyslexia**

The understanding of dyslexia amongst the tutors, in comparison to the mentors, was quite detailed, with discussions of different types of dyslexia, levels of severity and

difficulties in aspects of literacy. One commonality in the descriptions was particularly a understanding of how dyslexia may vary in presentation: tutor 3C, 'dyslexia takes many forms'; tutor 2B, 'more than one form of dyslexia'; tutor 1A, 'affects people differently'; and tutor 2B, 'more than one form of dyslexia'. This was in contrast to the mentors whose understanding was focused upon difficulties with literacy skills. As previously highlighted, there are currently only two studies that have explored the attitudes of nurse lecturers to dyslexia (Evans 2014; Major 2017). With reference to understanding of dyslexia, Evans (2014) found that there was variation amongst the nurse lecturers on their understanding of what dyslexia is, with discussion of either a mild or severe form, which is comparable to the responses of all the tutors here, describing dyslexia as presenting in different forms.

The study by Major (2017), which explores the personal and professional experiences of nurses with dyslexia and also interviewed nurse lecturers about their experiences, noted some lecturers spoke of how they raised the awareness of dyslexia at the beginning of a programme to ensure students would come forward for support. The majority of the lecturers in the study had some education on the process. It was previously highlighted in Chapter 3 that a recent report by Lukianova and Fell (2016) reported significant progress in making HE more accessible for people with disabilities and how there are many examples of good disability practice amongst UK universities (Atabey 2017). This increased accessibility for students with disabilities in HE, it is hoped, will continue to increase the understanding of dyslexia amongst academic staff and broadly, disabilities.

#### **7.4.2 Perceptions of Dyslexia**

In attempting to categorise the tutors' perceptions of dyslexia, a number emphasised the importance of support and that dyslexia should not hold them back or prevent them from becoming a nurse: tutor 3C, 'dyslexia shouldn't hold them back'; tutor 4D 'with appropriate support, can be very good nurses'; and tutor 6F, 'fully supportive to ensure they can achieve full professional careers'. However, in contrast, tutor 2B presented quite a different perspective, stating that a 'nurse with dyslexia should be able to do the job regardless of their dyslexia' and 'some are more able than others', reflecting an underlying feeling that dyslexia should not be really considered in terms of support, rather it is about getting the job done. Evans (2014) similarly found in his study, that there were a number of lecturers who placed greater emphasis upon 'getting the job done', rather than support for the student.

Tutor 1A commented that there could be 'concerns that you're more likely to make mistakes in practice if you're dyslexic', noting the differences between perceived perceptions within clinical practice surrounding dyslexic nurses. Nolan et al. (2015) noted in her study that some practice educators' concerns were whether the disabled student was able to 'do the job' within placement environments. Kelly and Watson (2013: 2) used a term, 'a closed system of thought', which describes what they view as an 'implicit discourse and contrary to aspirations of plurality, diversity and cosmopolitanism' within nursing. Such positions of 'getting the job done' in the context of perceptions of dyslexic nurses does challenge the equality and diversity ethos that should be a key consideration of the supportive nature of an academic clinical environment. Tee and Cowan (2012) interpreted such a position as lacking awareness of the obligations of legislation associated with supporting students with disabilities in

clinical practice. Major (2017) identified in her study, the key issue is the relationship between the lecturer and the nursing student with dyslexia to enable support and early disclosure.

Tutor 5E described how intellectual capacity is not determined by the presence or absence of dyslexia, adding support to the anecdotal belief that dyslexia is not a measurement of intelligence. However, definitions of dyslexia do point towards a difficulty despite adequate intelligence (Snowling 2000). Overall, the tutors had a positive and supportive perception of students with dyslexia. However, Madriaga (2007) noted in her study that schools, colleges and universities, for many of the respondents, are portrayed as spaces where tutors demonstrated their insensitivity and lack of awareness about disability issues and commented that 'disablism' is still evident in further and higher education. However, it is noted that this research is 13 years old; therefore, with the advent of the Equality Act (2010) and inclusivity in HE in more recent years, it is hoped there is a greater awareness and level of support surrounding disability issues in HE. With specific reference to nurse education, Storr et al. (2011) concluded there was a lack of evidence regarding the effectiveness of support for students with disabilities, once implemented.

#### **7.4.3 Experiences with a Dyslexic Student**

The experiences of the tutors with dyslexia refer to their experiences with their own students, who participated in this study. However, as highlighted in Chapter 5, it should be noted tutor 1A and tutor 6F were not personal tutors to the two students in the study (Emma & Chloe); rather, they were course directors and were not known to the students personally. Therefore, they gave their own generic experiences of nursing students with dyslexia.

The tutors who were personal tutors to their students spoke in positive terms of their students, with comments such as: tutor 5E, 'diligent, hardworking student'; tutor 2B, 'forget she's dyslexic'; tutor 3C, 'understood her dyslexia and level of support needed'; and tutor 4D, 'I think she's done really well'. This reflected a good level of support and understanding of dyslexia, but also that their students did not cause them any particular difficulty or concern. However, tutors 1A and 5E both stated they rely upon what the student tells them about their dyslexia or what their particular needs are. Therefore, this links back to the understanding of dyslexia and suggests some tutors are unsure of how to support nursing students with dyslexia. Tee and Cowan (2012) argued that support of students with a disability requires a high level of understanding amongst those responsible for their development and education. Additionally tutors 5E and 1A commented that they relied upon the student to tell them of their specific needs. Therefore, this calls for a need to educate and inform both tutors and mentors about dyslexia and how it impacts students both in HE and clinical practice. The study by Major (2017) noted that support from nurse lecturers for students with dyslexia varied from basic information on equality and diversity to a master's qualification in SpLD. Evaluation by Elliot (2010) highlighted that little education and training in equality and diversity is included in qualifying or post-qualifying NHS education.

Two of the tutors, tutor 1A and 5E spoke generically about supporting students with dyslexia and how supporting some dyslexic students was difficult: 'bit of a battle' and 'heavy need for support for dyslexic students'. This could be interpreted as placing emphasis upon the greater amount of work required by the tutors to support such students. Evans (2014) noted this concern amongst nurse tutors in his study in relation to the amount of time required to support such students. However, the focus on such

concerns related to dyslexic students who were described by the lecturers as having severe dyslexia. A number of tutors in this study, when describing their understanding of dyslexia, also described dyslexia in levels of severity or 'mild, moderate or severe' (tutor 6F, 1A), which demonstrates their awareness of the variable presentations of dyslexia. However, it is argued whether these descriptions are subjective impressions viewing dyslexia on a line of increasing severity and the difficulties this might bring in terms of academic support, perceiving dyslexia as a fixed or constant phenomenon (Hughes & Paterson 1997; Collinson & Penketh 2010).

Tutor 5E and tutor 1A made comparisons between dyslexics and non-dyslexics, stating that the academic difficulties dyslexics encounter are present in students with or without dyslexia: tutor 5E, 'some students with or without dyslexia, walking through sludge to pull them along'; and tutor 1A, 'some students struggle, academically, it's not because they're dyslexic'. This awareness of similar difficulties encountered in non-dyslexic students is astute and is presented in a number of studies (Price & Gale 2006; Sanderson-Mann et al. 2012; Crouch 2011).

## **7.5 Case 5 – Preceptors**

This final section of the discussion considers the preceptors who supported the registered nurse participants of this study in their first six months of registration. Five preceptors were interviewed, as part of this study and three main themes emerged from the data as follows: Understanding of dyslexia, personal experiences and perceptions of dyslexia.

There is limited research on the role of the preceptor in practice, specifically in support of nurses with disabilities. One particular study, highlighted in Chapter 3, by Johnston

and Mohide (2009), a Canadian study, which addresses diversity in clinical nursing education and support for preceptors. However, further examination of this study notes the term 'preceptor' is adopted to describe those who support senior nursing students, rather than newly registered nurses. Additionally, it is noted in the study by Evans (2014), which explores identity of nursing students with dyslexia in the Irish Republic, the term 'preceptor' is adopted to describe those who support nursing students in practice. Therefore, it appears the title of preceptor is used in a different context in different countries and is used in the same context as the term 'mentors' in the UK to support nursing students. This was further confirmed by Sharples and Elcock (2011), who commented that in countries outside the UK, the term 'preceptorship' is more usually used to describe a nurse who teaches students and other learners in the clinical area. A UK based systematic literature review, which examines the role of the preceptor in both the UK and overseas (Whitehead et al. 2013) presents a comprehensive review of the literature, but there is no mention of the support of newly qualified nurses with disabilities.

### **7.5.1 Understanding of Dyslexia**

Understanding of dyslexia varied amongst the preceptors; some had a more basic understanding of dyslexia focusing on difficulties with literacy: preceptor 1A, 'dyslexics find reading and writing difficult'; 2B, 'getting "Ds" and "Bs" back to front...spelling'; and preceptor 3C, 'they can't spell...can't do things as quick as others'. This had similarities to the understanding of dyslexia by the mentors in this study, with a focus upon difficulties with literacy. However, in contrast, others had a more detailed understanding of dyslexia: preceptor 5E, 'see written forms in a different way, need quieter area, words mixed up...trouble with sentence construction'; and preceptor 6F,

'words mixed up, different coloured transparencies, stop words jumping around page'. Preceptor 5E stated she had attended a post-graduate teaching course, including a day on dyslexia in which she gained her knowledge about dyslexia. Regarding the more basic understanding of dyslexia expressed by some of the preceptors, particularly preceptor 3C: 'they can't spell', perhaps this is interpreted as identifying an impairment in relation to their dyslexia.

Proponents of the social model of disability, Oliver and Barnes (2010) argued that although individuals may have impairments, these are only transformed into disabilities by the negative attitudes of the society they live in. Riddick (2001: 224) argued from this perspective that the impairments underlying dyslexia have only become a major difficulty because of the move towards mass literacy and the consequent negative connotations attached to being 'illiterate'. Nolan et al. (2015) noted one of the concerns expressed by practice educators with regard to healthcare students was the dyslexic's level and standard of writing, which potentially could affect the safe standards of record keeping.

In the UK, this form of preceptorship support for newly qualified nurses has been accepted since 1990 (UKCC, 1990) and has a specific definition: 'The process through which existing nurses and midwives provide support to newly qualified nurse and midwives' (NMC 2008: 46). Furthermore, the NMC explains that the preceptor should have at least one year's experience and have a teaching qualification (NMC 2006). Questioning surrounding clinical experience and teaching qualification was not asked of the preceptors in this study; however, apart from preceptor 5E, the other preceptors were more likely to have a mentor qualification rather than a teaching qualification.

There appears to be no singular study that has explored the experiences and perceptions of preceptors in relation to nurses with dyslexia in practice. However, Evans (2014) explored dyslexia identity amongst dyslexic nursing students and noted that the students felt their dyslexic identity was poorly understood amongst support teams including nurse preceptors. Additionally, a number of studies that have explored support of nursing students with dyslexia highlighted a lack of understanding amongst mentors about dyslexia (Morris & Turnbull 2006; White 2007; Ridley 2011). Additionally, Illingworth (2005) revealed that the participants in her study deemed increased dyslexia awareness important. Therefore, the roles of mentor and preceptor have similarities in terms of practice support; collective comparisons can be made across the roles of both mentors and preceptors.

### **7.5.2 Perceptions of Dyslexia**

The perceptions of dyslexia amongst the preceptors were of particular interest as they showed evidence of a shift in perceptions of dyslexia from two of the preceptors: preceptor 5E, 'first thoughts – quite tricky...saw it as a disability, but now I don't'; and preceptor 6F, 'much more tolerant than I was towards dyslexia with an increased knowledge'. Such shifts in perception of disabilities are known through an awareness of changing social attitudes towards disabilities (Bolt 2014), but remain an under researched area within adult learning environments. Brown and Stephens (1995), Lewis and Johnson (1982) and Stroud (1981) claimed that literature has the potential to influence the reader's attitudes and feelings and thus increase awareness of diversity. A study by Campbell et al. (2003) demonstrated how attitudes were changed amongst trainee teachers towards children with special needs through the use of formal instruction and focused information.

Preceptor 2B described her own attitudes towards people with dyslexia, commenting that 'society is vile to people with disabilities' and that 'lots of nurses are scared of people with disabilities'. She later revealed that she spent some years working within a college for adults with special needs, which appears to have influenced her attitudes towards people with disabilities. This further supports the evidence of changing attitudes to disabilities through exposure by Campbell et al. (2003). Preceptor 1A described his perception that 'dyslexic nurses just need that extra time, are not thick' and 'it is not in my nature to be derogatory to others'. He later spoke about an incident when he was a student where he was speaking about dyslexia to fellow nursing students and how he rebuked them when they were being derogatory towards nurses with dyslexia. Although there was no further evidence to determine his reasons for these perceptions, from this perspective, it suggests personal background or personality can influence attitudes towards disabilities.

In contrast, preceptor 3C commented that she was surprised her student had dyslexia as she was coping. This suggests an assumption by the preceptor that having dyslexia affects your overall ability to cope. She further commented that she had never considered dyslexia until she had met this nurse. This echoes the previously mentioned Oliver and Barnes (2010) argument in relation to the social model of disability: impairments that individuals may have are transformed into disabilities by society's view. Therefore, perhaps being a preceptor to this nurse was her first exposure to a person with dyslexia and her own thoughts about dyslexia were 'laid bare'. Attitudes to people with disabilities are multi-factual. The attitudes to people with disability are influenced by demographic variables, such as age, gender, nationality, marital status, educational grade level, socio-economic status, place of residence

(rural versus urban) and experience with disability (Chubon 1982; Yucker and Block 1986; Antonak and Livnah 1988; Paris 1993; Lyons 1990). It might be surmised that society's emphasis upon the importance of literacy (Snowling 2000; Burden 2008) and the relationship to literacy difficulties may have been an influencing factor in her perceptions.

### **7.5.3 Experiences of Preceptors to a Nurse with Dyslexia**

The experiences of the preceptors in supporting a nurse with dyslexia refer to their own experiences with the registered nurses who participated in this study. All the preceptors spoke positively about the nurses they supported. However, some made some revealing comments in relation to their dyslexia. Firstly, preceptor 3C commented that she 'would not have known she's dyslexic as she's doing very well'. Similarly, to her response outlined in perceptions of her dyslexia, she appears to be assuming that if someone has dyslexia, she would have an expectation of a specific problem or difficulty. This might be seen as judgemental as well as a negative attitude towards a person with dyslexia. Similar attitudes were also identified by Illingworth (2005) who noted some participants in her study were aware of the unjustified stigma sometime attributed to people with dyslexia. Additionally, preceptor 3C's comment, 'if I explain something to her, need to make sure she understands it' suggests the preceptor's fear of a potential safety risk.

Blankfield (2001), in her study entitled *Thick, costly and problematic? The dyslexic student on work placement*, described how risk and discrimination were constructed around a nurse with dyslexia within a clinical work placement because of the perceived risks by mentors. In his study of constructions of nurse lecturers' identities of nursing students with dyslexia, Evans (2014) noted one of the dominant themes that emerged

was the importance of getting the job done, from which he concluded that students requiring support are perceived disapprovingly. Preceptor 5E's comments, 'first thoughts, could be quite tricky' and 'extra aware, as did think there may be problems' presents this initial assumption of risk and extra support alluded to by Evans (2014). As with preceptor 6F's comment, 'dyslexia's a problem if they don't tell us' also presents an assumption of risk and perhaps a lesser awareness of the emotional impact of disclosure, and from a broader perspective demonstrates a culture present in the world of work of a lack of awareness of sensitivity to adults with learning disabilities (Crawford 1998). Nolan et al. (2015) quoted a fear of a practice educator in her study who was concerned a student would one day have to practise independently and thus as practice educators we have a responsibility to protect the patient, public and the nursing profession. Newton et al. (2012) commented that tensions between meeting the learning needs of students and the demands of practice continue to generate difficulties in clinical practice environments.

Preceptor 1A expressed his shame that he did not know his nurse was dyslexic; a comment that reveals his own thoughts about his duty as a preceptor to a nurse who has a disability. He also described how he had designed a coloured grid to make it easier for her. This demonstrates a preceptor who appears to be very much in tune with his duties and responsibilities to a nurse who has a disability. A supportive approach by mentors towards students with disabilities has been reported in a number of studies (Sanderson-Mann and McCandless 2005; Morris & Turnbull 2006; White 2007; Ridley 2011). Child and Langford (2011) identified that mentors need to be aware of the nature of dyslexia, such as knowledge of practical ways to help them. From this perspective, preceptor 1A appears to have fulfilled this practical knowledge.

Preceptor 2B commented that her student 'didn't come over as dyslexic as she was very confident' and preceptor 6F commented, 'really good nurse, despite her literacy difficulties', which are positive in the sense of praise for their nurses' ability. However, there remains an assumption here of a perceived expectation of a difficulty or risk surrounding dyslexia. There is no denial that an individual with dyslexia does experience a variety of difficulties in practice (Sanderson-Mann and McCandless 2005; Morris & Turnbull 2006; White 2007; Ridley 2011). However, is there a focus here upon the identity of the assumed difficulty rather than the person's abilities? Identities can be constructed discursively (Caldas-Coulthard & Fernandes-Alves 2008). However, these can potentially be altered through both talk and interaction (Taylor & Littleton 2006). Are these comments by preceptors 2B and 6F constructing an identity around what they perceive about dyslexia? Has a dyslexic label been attached through a single identity of a perceived difficulty, in this case literacy difficulties and lack of confidence? Evans (2014) highlighted evidence that students are aware that they may develop a marginalised identity after disclosure of their dyslexia. In this context, there appears to be evidence here that both preceptors have focused on their own perceived difficulty of dyslexia, but at the same time highlighted a positive evaluation of the nurse in question, subtly revealing their own discursive identity of dyslexia in the process.

## **7.6 Discussion of NMC Documents**

In Chapter 6, a document analysis of three NMC documents, which detailed guidance and policy on the admission of students onto undergraduate nursing programmes, was undertaken.

In summary, these documents provided guidance to potential nursing and midwifery students and approved educational institutions. From a broad perspective, these documents appeared to take quite a broad medical focus upon health and disability and as noted in this discussion, not every disability has a medical basis, particularly specific learning difficulties (SpLD) such as dyslexia. The *Character and health decision-making guidance* (NMC 2015c) makes no reference to the word, 'disability' until page seven. Additionally, there is also quite a medical focus when reference is made to 'factors to consider when assessing health' using terminology such as 'treatment' and 'condition'. There is also reference to GP or occupational health reports. In presenting a medical focus, this relates to the medical model of disability. The medical model of disability says disabled people are disabled by their impairments or differences, and these impairments or differences should be 'fixed' or changed by medical or other treatments (Scope 2018). The RCN (2016: 3) argued that this way of thinking about disability is at the root of many issues facing health care professionals with impairments as they train and work. It is argued that not all disabilities have a medical cause; many will not require the opinion of a GP or medical professional.

Brisenden (1986) argued that disabled people live in a world run by non-disabled people. This is clearly an early piece of work prior to the Disability Discrimination Act (HMSO 1995) and the Equality Act (2010), and employment rates for people with disabilities have risen to 1.3 percentage points higher in April-June 2017 than in the same period in 2016. In this period, the number of people with disabilities in employment has risen by 104,000, but in contrast, people with disabilities had an employment rate of 31.3 percentage points lower than people without disabilities between April and July 2017 (House of Commons Library 2018). Within the nursing

profession, there are 33,345 registered nurses, who have a disability out of 647,605 nurses on the nursing register 5.2% of the total. Within midwifery, there are 1,704 midwives with a disability out of 34,554 midwives on the midwifery register, 5% of the total (NMC 2017a). It should be noted that these figures and percentages do not include those who have not declared a disability. Therefore, these figures suggest that nurses and midwives with disabilities remain low in comparison to the non-disabled nurse and midwifery population. Reasons for these percentages remain unknown. It was highlighted in section 7.4 of this Chapter that Lukianova and Fell (2016) reported significant progress in making HE more accessible for people with disabilities; however, the figures highlighted suggest there is still some way to go.

With specific reference to disabilities, such as dyslexia, medical opinions of GPs or occupational health are not appropriate for a person with dyslexia; rather, educational psychologist reports would be more relevant to such difficulties.

The second document, *When studying to be a nurse or midwife – good health, fitness to practice and guidance* (NMC 2016b), now adds disability advisor to the list of referrals required for assessment, which is a further development from the *Character and health decision-making guidance* (NMC 2015c) where disability advisors are considered for assessment, rather than medical practitioners. However, the inclusion of criminal convictions as part of this statement next to health and disabilities is confusing as well as concerning. Whether the reason for its inclusion may apply to similar regulations that may require similar screening prior to entry to the programme is unclear; however, its inclusion here does not appear appropriate.

The third document, *Health and character guidance for approved education institutions (AEIs)* (NMC 2016c) is targeted at UK educational institutions that recruit onto undergraduate nursing and midwifery programmes. One significant observation is the statement that the NMC does not regulate nurses and midwives; rather, it is the responsibility of AEIs to assess the health and character of students and prospective students according to their own policies and processes. This places sole responsibility on the AEIs to determine the fitness of potential students as well as their entry to the nursing register. This may have the potential to result in variation and inequality around the country in decisions over recruitment of potential students with either a health condition or disability. This could result in inequity over recruitment within UK institutions.

## **7.7 Chapter Summary**

This chapter has provided a discussion of the key themes that have emerged from the analysis of the data in relation to the nursing students/registered nurses, mentors, tutors and preceptors. Adopting a case study approach, a narrative discussion has presented a detailed dialogue of some of the key themes referring to previous references to support the discussion, as well as presenting new evidence to highlight further emerging themes.

These key themes will be summarised in the subsequent conclusion chapter (Chapter 9) referring to the specific research questions and making recommendations for future research, reflecting upon new thoughts or theories that have emerged from this study.

## **CHAPTER 8: Further Development of the Theoretical Framework**

### **8.1 Introduction**

In the previous discussion chapter, I referred to the work of Frith (1995) in relation to the students/nurses in my study; specifically the relevance and relationship of Frith's shared framework for dyslexia. I made a number of references to Frith's framework in relation to my data. Specifically, the contrasting school experiences of Lucy, Marie and Olivia: the positive experiences of support alluded to by Lucy and Marie, but also the negative experiences and feelings of Olivia and the influence of the environment on these experiences. Additionally, I also made reference to Frith's framework in relation to the cognitive difficulties some of the students experienced, specifically aspects of documentation including pronunciation of words and spellings. I posed a need to track the difficulties from childhood to adult dyslexia, for which Frith's framework was initially designed, for the analysis of schoolchildren with dyslexia.

In this chapter, I consider a further development of the theoretical framework in light of the appropriateness of the Frith framework in relation to my data. As highlighted in Chapter 2, the Frith framework has a number of elements that are relevant to my study including the influence of environment and cognitive and behavioural levels of description. However, its original purpose for use with children with dyslexia makes it of lesser relevance for a study of adults with dyslexia. Patton and Polloway (1992) commented that adults with dyslexia should not be regarded as children with a learning disability grown up, and that their needs are quite different. Specifically, many may

have adopted strategies for their difficulties as an adult or just adapted to their difficulties. I therefore now consider the Frith framework alongside a number of other frameworks and collectively consider and develop a new framework that could potentially be adopted as an alternative to interpret similar data such as mine that explores adult dyslexia.

## **8.2 Development of the Framework**

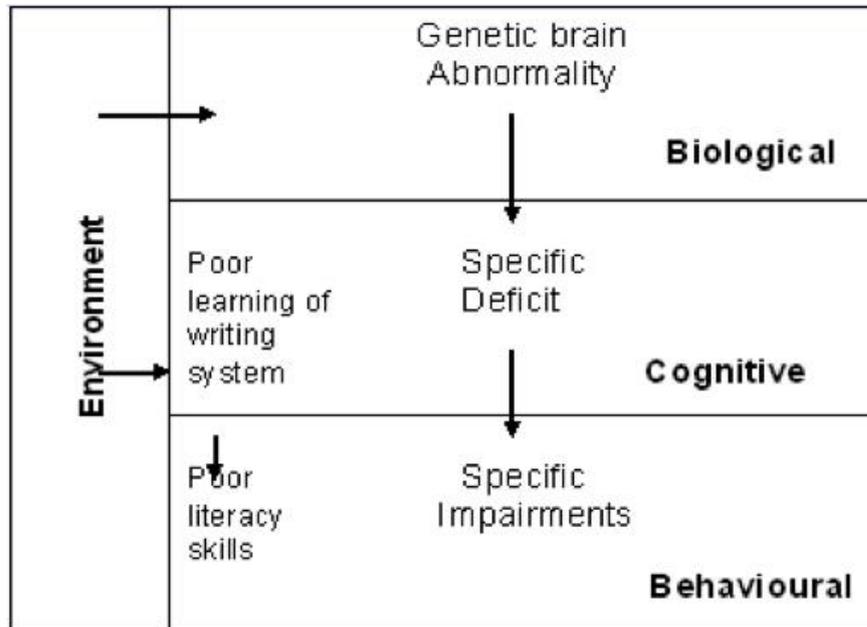
I now take an introspective look at my data in relation to the development of a new framework, in light of what has emerged from the data. There is evidence of a negative self-perception or self-stigma by some of the nurses, which also appears in aspects of their discussion surrounding documentation, clinical handovers and drug administration, mainly through fear of others' perceptions over their ability in these tasks. Additionally, there is some evidence of the influence of school experiences in adulthood, and potential influence upon their experiences and perceptions as nursing students and later registered nurses. Collectively some aspects of their discussion require closer analysis within a framework to identify patterns or themes across a number of levels of the findings of my study. This chapter describes the process of the development of the retrospective theoretical framework discussing the influences of two key frameworks, namely the Frith Shared Framework for Dyslexia and the WHO International Classification Framework (ICF) for disability (WHO 2001).

The key area of focus within my study has been the lived experience of dyslexic nursing students who later become registered nurses. This study further considered the understanding and perceptions of the participants' own dyslexia from their own perspective. In formulating and constructing a theoretical framework for my study, I

return to the original purposes outlined in the methodology chapter and specifically section 4.5, which aimed to interpret the experiences of these nurses through their own voices. Additionally, section 4.6 I discussed further the theoretical framework in the context of the underpinning philosophical elements of my study; one of these elements being social constructionism. In Chapter 2, I referred to Frith's Dyslexia Framework in the context of a shared framework of dyslexia which Frith (1995) stated she devised to bring order into the chaotic world of reading problems, dyslexia and learning disability. Additionally, adding to the world Frith describes through this framework, I wish to allow an unambiguous contrast between dyslexics and non-dyslexics. This is significant to the findings of my study from the perspective of my observation of a need for further comparative studies that consider dyslexic and non-dyslexic samples rather than focusing solely on dyslexic sample populations.

### **8.3 Frith Shared Framework**

Frith (1995) divides her framework into three levels of description surrounding dyslexia: biological, cognitive and behavioural. Biological refers to neurological functioning and the underlying genetic basis of dyslexia. Cognitive considers the perceptual and cognitive underlying causes of poor reading performance, which may include phonological deficits as well as emotional factors. Behavioural considers the observation of specific difficulties or impairments in learning in reading and writing such as poor literacy skills. Alongside these elements are environmental influences, which might affect and influence all of these three levels, such as attitudes of others or the complexities of an educational environment or workplace environment for example.



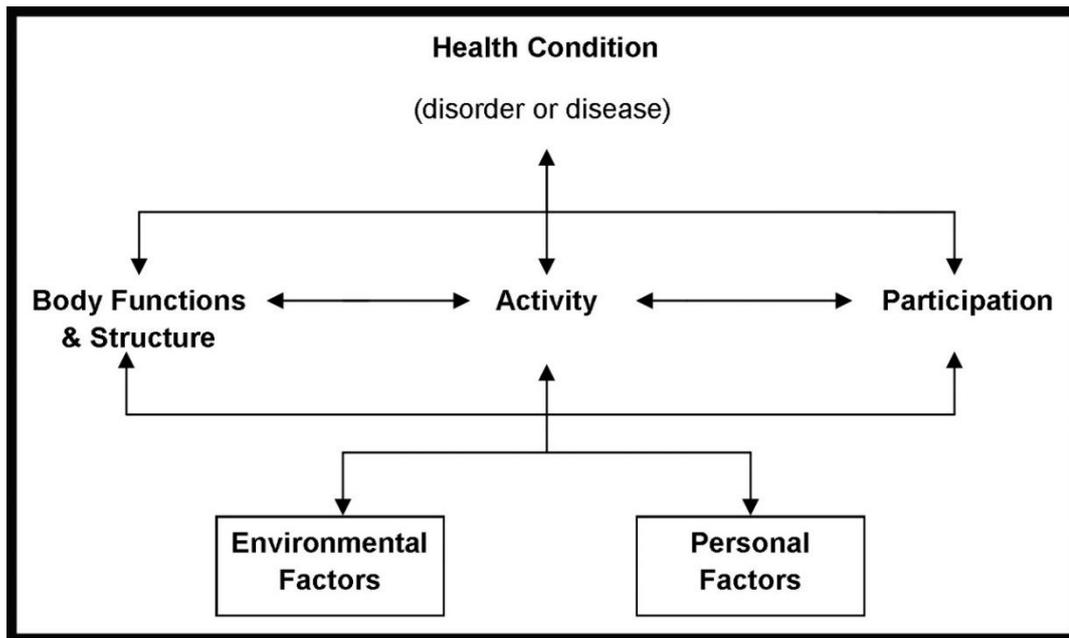
**Figure 8.1 – Frith’s Dyslexia Shared Framework**

In examining the details of Frith’s framework (Figure 2.1) in the context of my own study and in the formation of my own theoretical framework, my initial thoughts were that one level of this framework was not relevant to my own study, specifically biological. The biological level is concerned with a genetic origin of dyslexia, which Frith emphasises as her own view, but also with evidence of any brain abnormalities, which potentially impact upon phonological processing (Galaburda 1989; Rumsey et al. 1992). The genetic origins of dyslexia, as well as the biological elements of dyslexia, are not apparent within the research questions of my study; thus, they are not relevant and beyond the limits of my study. However, in contrast, the cognitive and behavioural levels are very relevant in respect of the difficulties and associated emotional impact amongst the nurses in my study. Additionally, what is particularly relevant is the environment, which can potentially influence the difficulties an individual with dyslexia experiences, through either the attitudes or approaches of an individual towards a

person with dyslexia or a non-supportive environment such as a school or workplace. In developing this framework, Frith aims to make links and relationships between levels looking for causative factors or reasons for the difficulties experienced. However, one key factor of Frith's framework that does not match with my study is that the framework was designed originally for the purposes of children with dyslexia who are poor readers. As my study is focusing solely upon adults with dyslexia and not children, my immediate thought was that this framework was of lesser relevance in this respect. However, there are certainly elements of Frith's framework that are still of importance to my study, specifically the cognitive and behavioural levels, which identify any phonological deficits and/or any emotional factors as well as any specific difficulties in aspects of literacy.

#### **8.4 International Classification of Functioning, Disability and Health**

In continuing to construct my own theoretical framework, I also explored the International Classification of Functioning, Disability and Health (ICF) (WHO 2001) (Figure 8.2). This is defined as a framework for describing and organising information on functioning and disability and provides a standard language as well as a conceptual basis for the definition and measurement of health and disability. The ICF approved for use by the World Health Assembly in 2001, integrates the two major models of disability, namely the social and medical models of disability. The ICF conceptualises an individual's level of functioning as an interaction between their health conditions, environmental and personal factors.



**Figure 8.2 – International classification of functioning, disability and health (WHO 2001)**

A broad perspective of disability could be described as multi-dimensional in nature, a variant presentation from one person to another. Therefore, it is argued you cannot ‘pigeon hole’ disability in any one person, rather you can describe its presentation in that individual as well as its physical, social and environmental impact. With direct reference to my own study, with its focus upon dyslexia, similarly to disability, it is argued you cannot slot dyslexia into a box of characteristics or categories either. Miles et al. (1998) described dyslexia as a family of lifelong manifestations that reveal themselves in many other ways than just poor reading. In this respect, the ICF attempts to contextualise the many factors associated with disability and health through a detailed classification of body functions and impairments in body function or structure. It is argued that taking a biological structural approach places disability in the context of the medical model. The medical model views disability as a problem of the person,

directly caused by disease, trauma or any other health condition, which requires medical care provided in the form of individual treatment by professionals (WHO 2001). In this context, management of the disability is aimed at the cure or the individual's behaviour change (WHO 2001: 20).

With reference to the medical model and disability per se, disability is not always directly associated with disease or even health; not everyone with a disability can be described as 'sick'. Dyslexia, or more specifically developmental dyslexia, has no connection to health or disease, unless it might be acquired due to brain injury or trauma; rather, it can be described as an intellectual disability in contrast to a physical disability. In contrast, the social model of disability is where disability is viewed as an outcome of social arrangements that work to restrict the activities of people with impairments through the erection of social barriers (Thomas 2002). Disability is not an attribute of an individual, but rather a complex collection of conditions many of which are created by the social environment (WHO 2001).

The ICF claims its creation is based upon an integration of both the medical and social models and takes a biopsychosocial approach to integrate the various perspectives of functioning, and attempts to create a synthesis to provide a coherent view of health from biological, individual and social perspectives. However, on closer examination of the ICF and with direct reference to my own study, the ICF views health conditions and disabilities collectively and processes and maps the constructs and domains through a classification of body functioning. It clearly states it does not model the process of functioning and disability, but rather it can be used to describe the process using a mapping process from a detailed list of categories and definitions.

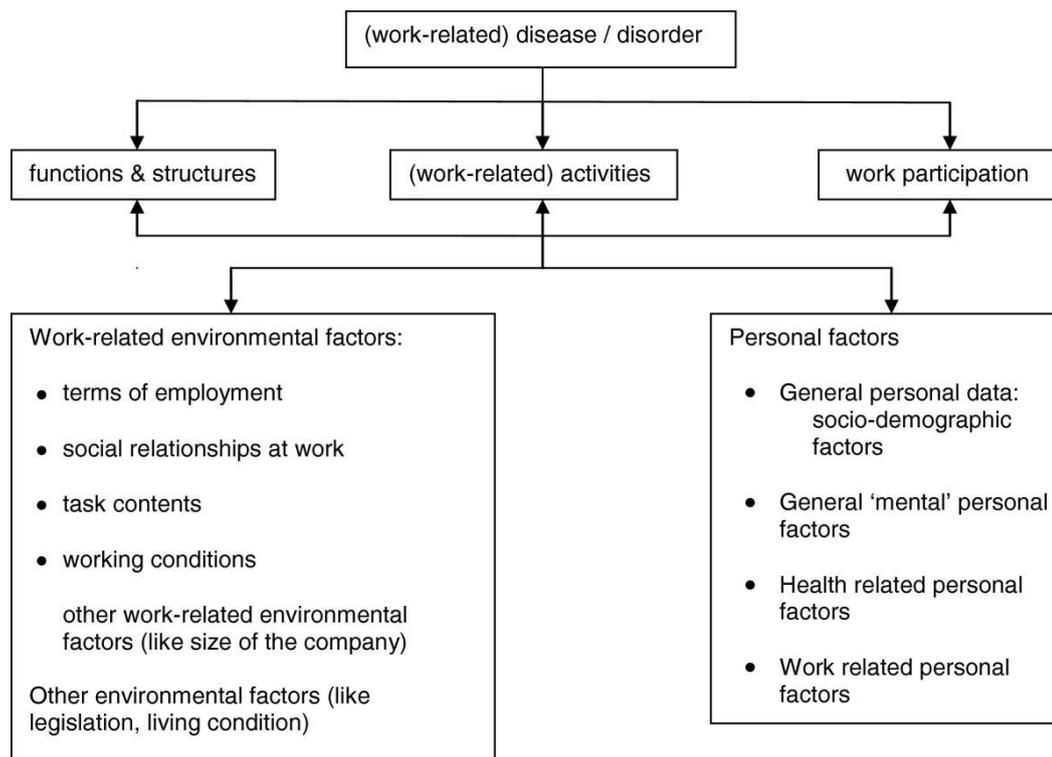
In respect of this description, I began by initially searching the categories to identify the difficulties and characteristics associated with dyslexia. The ICF has a broad and comprehensive section of four detailed classifications of 'body function', 'body structure', 'activities and participation' and 'environmental factors'. From these four broad classifications they are separated further into eight chapters, which list specific characteristics to identify aspects and factors associated with a particular disability. In searching through the ICF classifications, I identified a number of difficulties associated with dyslexia, including memory function, higher level cognitive function and calculation function.

These correlate to a number of common difficulties associated with dyslexia, highlighted in Chapter 3, the literature review. These include evidence of short-term memory difficulties in nursing students, reported in a number of studies (Morris & Turnbull 2006; White 2007; Child & Langford 2011; Ridley 2011). Additionally, organisational skills and time management have also been reported as difficulties amongst dyslexics (Price & Gale 2006; Cooper 2009). Difficulty with calculations is a difficulty often associated with dyscalculia, but also a difficulty experienced by dyslexics (Morris & Turnbull 2007b; Crouch 2008; Sanderson-Mann et al. 2012).

Additionally, I also considered societal attitudes towards those with dyslexia as well as the evidence of stigma that surrounds dyslexia. Within the ICF, a chapter entitled 'Attitudes' considers such attitudes towards an individual with either a disability or health condition and how these attitudes might influence individual behaviour and social life. As with the previous search, I identified a number of classifications that can be associated with attitudes towards an individual with dyslexia in the context of my

own study: individual attitudes of health professionals, individual attitudes of other professionals and societal attitudes.

However, in respect of the ICF, as it is designed for a multitude of disabilities and health conditions, it could be argued the broadness of the ICF makes it less appropriate for a very specific disability such as dyslexia. A number of researchers have adapted the ICF for their own use. De Beer et al. (2014), who explored factors that influenced work participation of adults with developmental dyslexia through a systematic review, adapted the ICF framework using the addition of work environmental factors to the ICF by Van Dijk et al. (1990) and a subdivision of personal factors added to the ICF by Heerkens et al. (2012) (Figure 7.2).

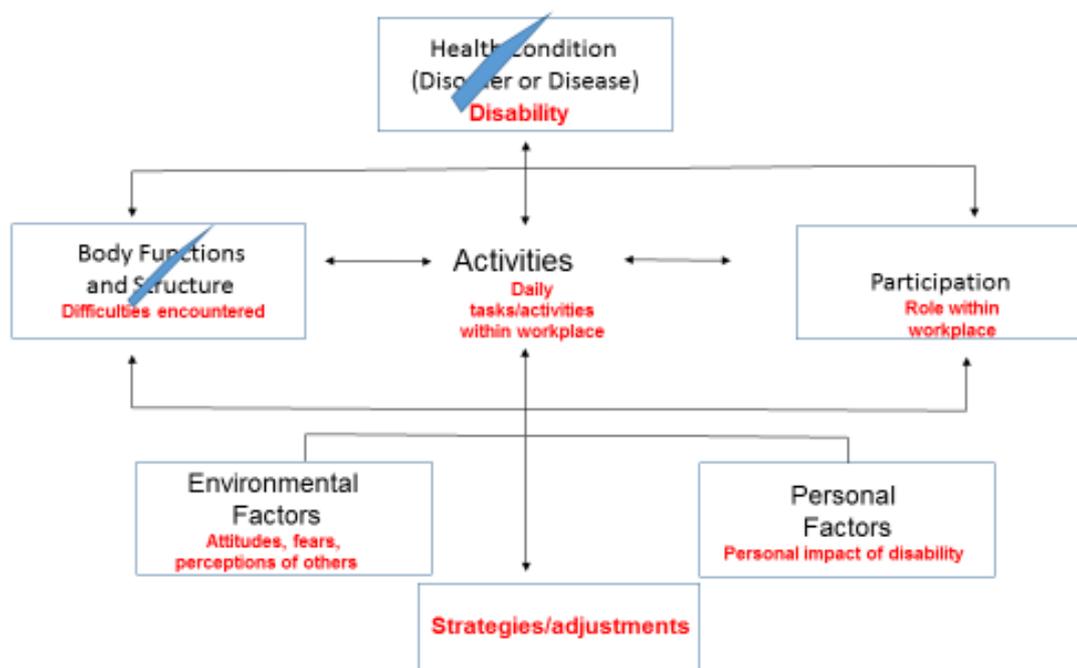


**Figure 8.3 – The original ICF scheme is expanded with concepts from the model of Van Dijk et al. (1990) and from a proposed subdivision of the personal factors (Heerkens et al. 2012)**

In respect of these adaptations made to the ICF by De Beer et al. (2014), Van Dijk (2009) and Heerkens et al. (2012), I further considered the ICF in the formation of my own framework with adaptations made from Frith's framework. I firstly considered the lesser relevance of the medical model of disability to my study, specifically the emphasis upon viewing disability as caused by trauma, disease or a health condition. In contrast, I considered the social model, which I view of greater relevance to my study with its view of disability as a socially created problem. I began to consider the greater emotional and sociological impact of dyslexia upon those with dyslexia.

I first took the ICF and made a number of changes replacing the term 'health condition' with 'disability' and 'body functions and structure' with 'difficulties encountered' (see

Figure 8.4 Adapted ICF). These changes were influenced by the Frith framework for dyslexia with an emphasis upon the behavioural levels of description, specifically difficulties or impairments. Secondly, I made further changes adding 'daily task/activities within workplace' to 'activities' and added 'role within workplace' to 'participation'. My focus was upon the workplace or work placement, influenced by the expanded concepts to the ICF by Van Dijk et al. (1990) of work related environmental factors (Figure 8.3). Thirdly, in considering the emotional and sociological impact of dyslexia, I added further detail to the environmental factor and personal factor elements of the ICF, listing 'attitudes, fears, perceptions of others' to environmental factors and 'personal impact of disability'. As previously highlighted, the social model of disability remains both a strong influence and relevant to my study in the context of the original study purposes to interpret the experiences of nurses with dyslexia through their own voices, potentially revealing the negative perceptions of others.



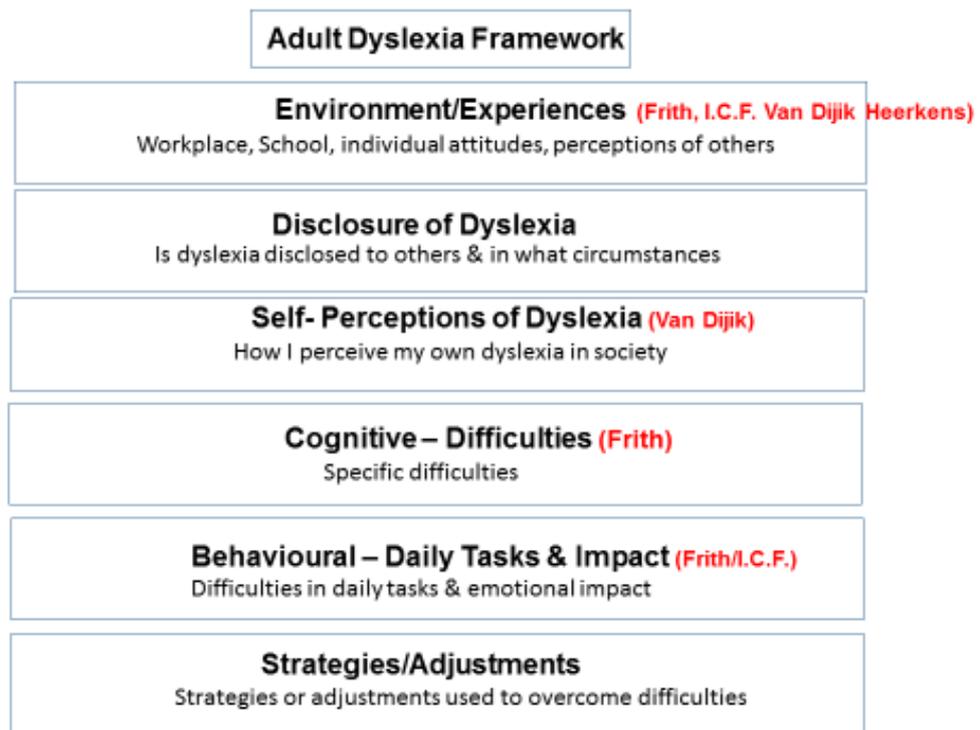
## **Fig 8.4 – Adapted ICF**

The subdivisions of work related environmental factors of the ICF (Heerkens et al. 2012) added more detail to the environment, including social relationships at work coupled with Van Dijk's subdivision of personal factors (Figure 8.3). This provided me with further influence and thought over the significance and emphasis of personal factors and environment in terms of the associated impact of these upon disability and specifically dyslexia, such as attitudes of others and adjustments in the workplace.

## **8.5 Development of the Adult Dyslexia Framework**

As has been highlighted earlier, in my view one of the disadvantages of the ICF is its breadth in classifying and categorising an immense number of disabilities and health conditions collectively. The design of my framework incorporated both elements of the ICF and Frith's dyslexia framework. This framework needed to include factors that collectively form elements of both the ICF and the Frith framework, specifically environment and personal factors, as well as the cognitive and behavioural elements of Frith and the influences of the ICF adaptations by Heerkens et al. (2012) and Van Dijk (2009). All these models and associated adaptations influenced the design of my own framework, which are highlighted in the associated sections within this framework (see Figure 8.5).

I divided my framework into six specific sections or levels of description (Figure 8.5). Each of these sections has a short description to present a background to each section guiding the user to what each section is focused upon. As my framework's focus is upon adults with dyslexia, I entitled my framework, the 'Adult Dyslexia Framework'.



**Figure 8.4 – Adult Dyslexia Framework**

The first section **Environment/Experiences** considers the influence of the environment upon the person with dyslexia. The environment could be the school environment, the workplace or both. Additionally, this section considers the attitudes and perceptions of others within this environment, thus considering the impact of others upon the person with dyslexia.

The second section **Disclosure of Dyslexia** asks whether the person discloses their dyslexia to others and in what specific circumstances. A number of research studies in the literature review chapter influenced this section. These highlighted that a number of nursing students and nurses remain unwilling to disclose their dyslexia to others or will only disclose in specific circumstances; (Sanderson-Mann & McCandless 2005;

Morris & Turnbull 2006, 2007a, 2007b; White 2007; Illingworth 2005, Ridley 2011; Sanderson-Mann et al. 2012).

The third section **Self-perceptions of Dyslexia** asks the person with dyslexia of their own perception of their dyslexia. This section considers the societal viewpoint of dyslexia from the person with dyslexia rather than the perception of others. This section particularly considers stigma, which has been particularly evident in my findings.

The fourth section **Cognitive – Difficulties** asks the person with dyslexia if they experience any specific difficulties, whether these are literacy difficulties, organisational difficulties etc. These difficulties can be very specific to the person with dyslexia.

The fifth section **Behavioural – Daily Tasks and Impact** considers further the difficulties the person with dyslexia experiences and the actual impact of these difficulties.

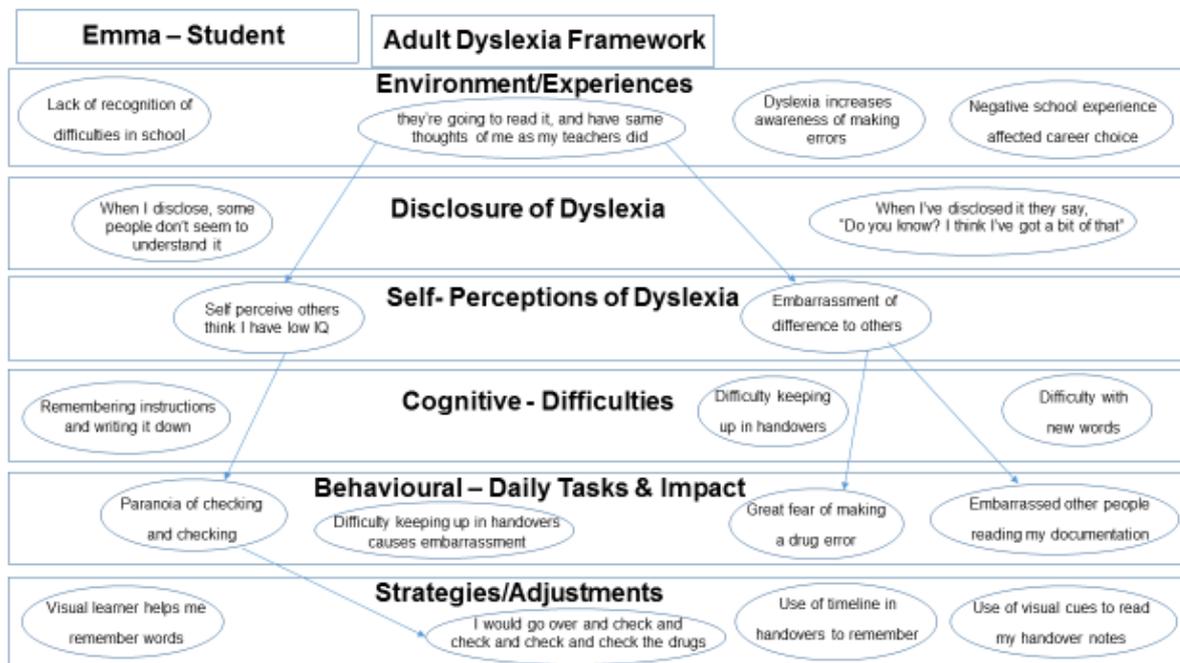
The sixth and final section **Strategies/Adjustments** asks the person with dyslexia if they adopt any strategies or adjustments to overcome their difficulties. These strategies or adjustments may be quite recent strategies if the person has recently commenced new employment or have been established over many years.

In designing and focusing this framework, my aim is that it is used in qualitative studies where data from an interview or discussion has been collected for the purposes of research evidence with an adult or adults with dyslexia, allowing such data to be collated across individual sections or levels of description. However, in attempting to embrace the influences of the Frith framework and ICF framework, my framework aims

to make links or relationships across sections. For example, how the impact of non-disclosure of dyslexia might be linked to a person's self-perception of themselves. This might be linked to a negative school experience. These links or relationships are made across key statements by the participants within each section or level of description. From these links, relationships can be determined between each level identifying either causative factors or reasons for difficulties, again taking influence from the design and objectives of Frith's shared framework.

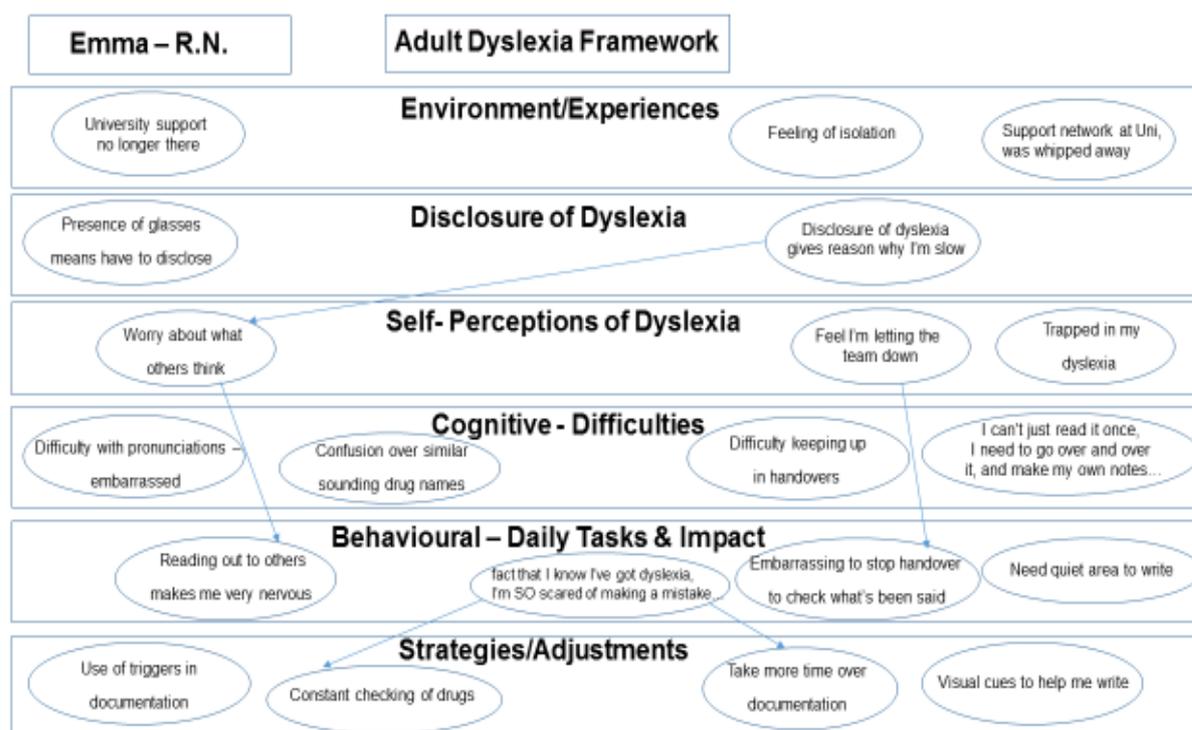
## **8.6 Adoption and Critique of the Adult Dyslexia Framework (ADF)**

In order to test this new framework, I decided to evaluate the use of the framework with my own data to determine how effective it might be. I used the data by taking direct quotations from each participant and placing them within each appropriate level of description. I then made any links or connections across quotations that had some relationship; for example, whether this difficulty was apparent at school and as an adult. My first thoughts as I began to input the data were that the framework gave me a more visual presentation of the considerable amount of data in my study, compared to when written and discussed in text form. The following is the framework used for Emma as a student (Figure 8.5)



**Figure 8.5 – ADF Emma – student**

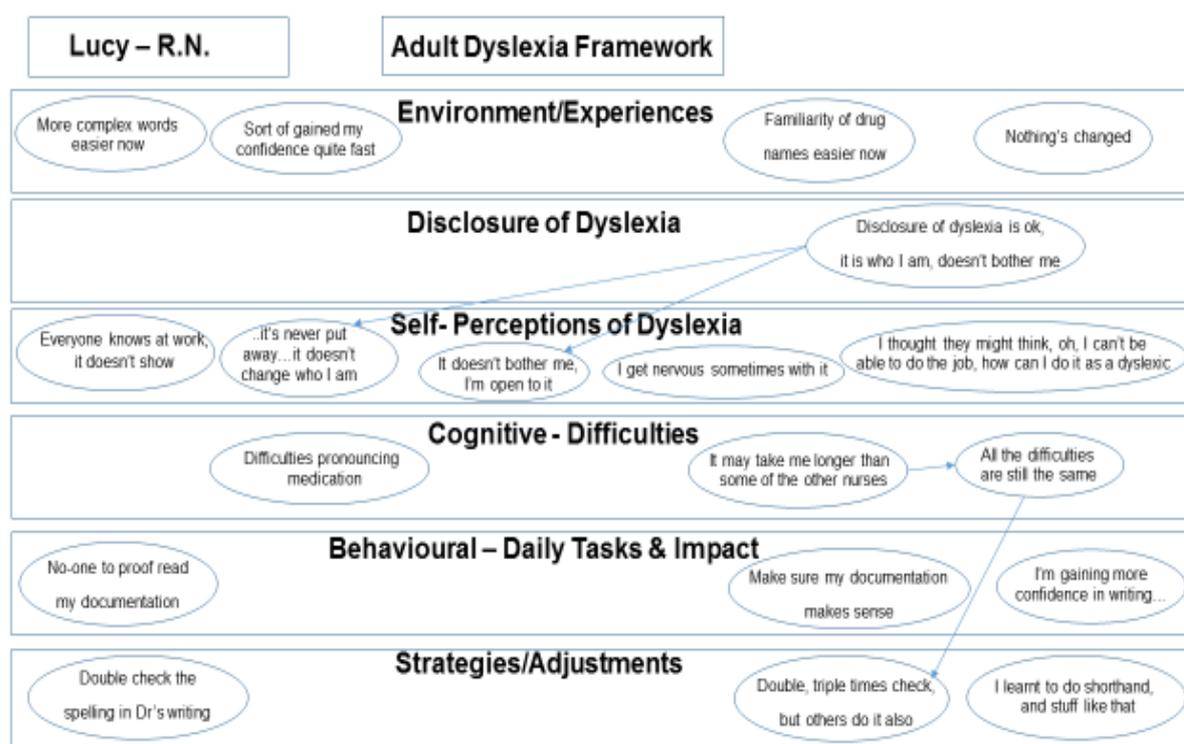
Clearly, this presents Emma in this framework as a student. As my study is a longitudinal study and collects data at two distinct points, there is a requirement to use the framework to cover these two separate events. Additionally, there is limited space within each 'level of description' box; therefore, this restricts how much wordage you can place here. This could prove difficult if a participant provides large amounts of data, resulting in not all information being selected. One solution to this is to summarise key points rather than using direct quotations. I also used the framework to explore the data of Emma as a registered nurse (Figure 8.6).



**Figure 8.6 – ADF Emma – RN**

Now observing Emma as a registered nurse in contrast to a student using the framework, I could make comparisons across the levels of description. Looking across this framework, I felt, however, that the ‘Cognitive – Difficulties’ and ‘Behavioural – Daily Tasks and Impact’ were not precisely clear in terms of what they were observing. I referred back to Frith’s framework to consider the precise meanings of these levels of description. Frith (1995) stated that the cognitive level can include emotional factors and must be strictly separated from the observed behavioural level as they can be distantly inferred. However, I considered again Frith’s use of her framework for children rather than adults and whether these apply in the same context. Adults with dyslexia will have a number of difficulties, which may or may not be connected to emotional factors. However, I reconsidered this observation in respect of my own data and the

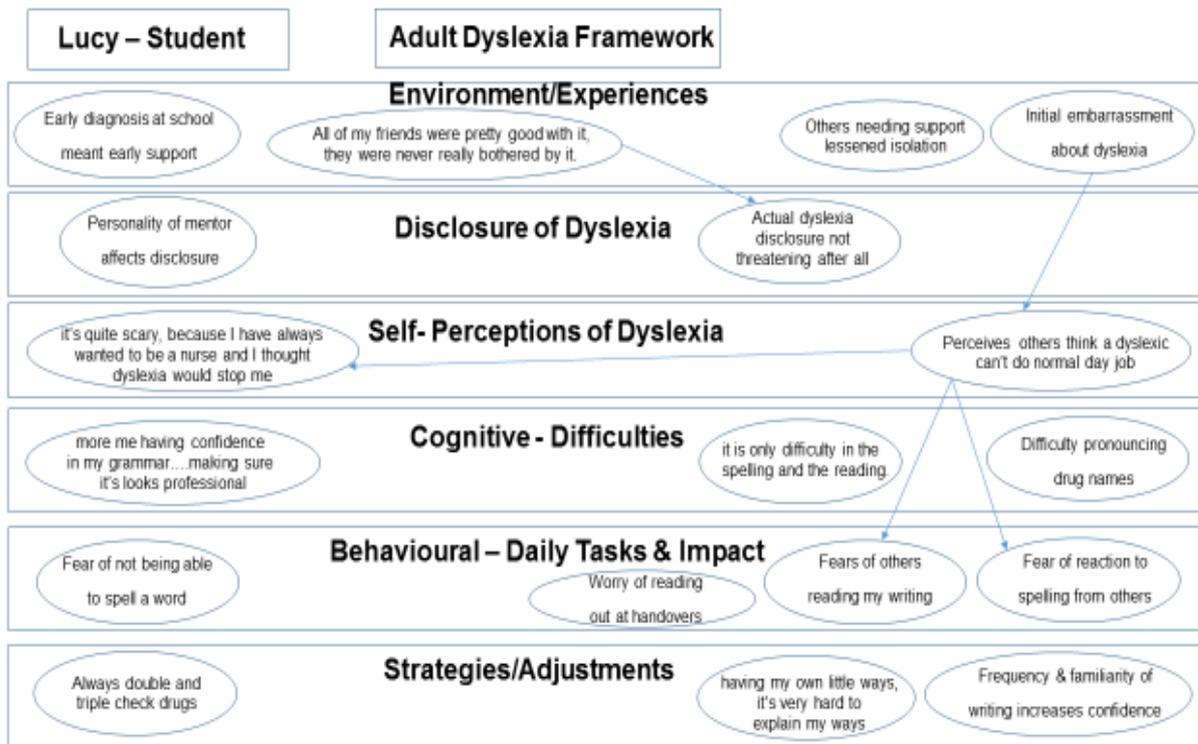
links to self-stigma expressed by a number of the participants. Therefore, whether 'cognitive' in the ADF must refer directly to difficulties, whilst behavioural to the impact of these difficulties, with regard to the nurses own thoughts and perceptions surrounding such difficulties. In respect of this and taking Emma as an example, this has been inputted correctly in terms of her description of paranoia when checking drugs and fear of making a drug error, so combining her difficulties and associated feelings about them These specific elements link also to self-perception such as embarrassment of being different from others.



**Figure 8.7 – Lucy – RN**

I also used Lucy as another example to test out my framework. The self-perceptions data from Lucy as a registered nurse (Figure 8.7) showed she was much more open

about her dyslexia. When making a contrast to her experience as a student, the framework showed some differences as shown in Figure 8.8:



**Figure 8.8 – Lucy – student**

Her self-perceptions as a student are different describing her experience as a student nurse with dyslexia as quite scary and perceiving others as thinking you cannot do a normal day job if you have dyslexia. These two frameworks show the differences that are apparent in Lucy from student to registered nurse. What is of particular value from my perspective is the visual display of the data rather than viewing the data in analytical tables. Additionally, what I have found of value in the analysis of the data is the visual diagrams of the different themes apparent in Chapters 5 and 6 of the analysis chapters. This perhaps was one of the considerations of devising this framework to visualise the data better.

## 8.7 Summary of Chapter

The testing and evaluation of this Adult Dyslexia Framework have been influenced by the Frith shared dyslexia framework (1995) and the ICF (2001). Aspects of the Frith framework, such as the cognitive and behavioural levels of description, which focus upon the causes of poor reading and specific difficulties experienced by those with dyslexia, were key influences. However, the targeted design of the Frith framework towards children rather than adults made it less relevant to be wholly adopted as a framework for my own study. The broadness of the ICF (2001) and its objective to consider many disabilities and health conditions made this framework less specific to dyslexia due to the unique variable presentation of dyslexia. However, its adaption by others and the addition of personal factors by Heerkens et al. (2012) and work related environmental factors by Van Dijk et al. (1990), which was specifically adapted in a systematic review surrounding developmental dyslexia by De Beer et al. (2014), demonstrated how such a framework might be adapted to your own needs and research focus.

I first made changes and adaptations to the existing ICF framework (Figure 8.4). However, these adaptations still presented me with a less usable framework for adults with dyslexia. This led me on to designing my own framework, the Adult Dyslexia Framework. This framework encompasses six sections or levels of description relevant to an adult with dyslexia in terms of the impact of environment, disclosure, self-perception, difficulties and strategies. The inclusion of the environment, cognitive and behavioural elements in this framework were taken from the Frith framework (1995). Additionally, influences from Van Dijk et al. (1990) and Heerkens (2012) also added to these influences.

This framework presents a more rounded perspective to visualise my themes as a whole, rather than considering them singularly and later analysing them collectively. My intention is to consider the testing and evaluation of my framework for its potential use in future research of adults with dyslexia following the conclusion of this study.

## **CHAPTER 9: Conclusion**

### **9.1 Introduction**

This chapter outlines the conclusive discussion of this study's findings, providing a summary and overview of some of the key themes and additionally providing answers to the research questions, outlined at the end of Chapter 3. Limitations to this study are first presented, detailing aspects of this area of study where there are limits in considering, answering or covering areas of this topic. Reference will then be made to the theoretical framework outlined in Chapter 8 and its implications for future practice and research. Reference will be then made to the research questions, presenting a summary according to the findings in relation to each question. An account will then be presented, which will discuss the need for future research surrounding dyslexia in nursing in light of the findings of my own study. The chapter will conclude with some final thoughts at the completion of my research.

### **9.2 Limitations of the Study**

There are a number of limitations to this study. Firstly, the sample size across all the participants in this study was small, which restricts the breadth of the data gathered. However, as noted in previous chapters, this is a case study and so the aim was not in any way to make generalisations from the data; rather, its purpose was to provide in-depth insight into the experiences and perceptions of the participants.

Secondly, Holloway and Wheeler (2002) noted that research participants sometimes react to the researcher and modify their answers to please or appear to the researcher

in a positive light, which has been highlighted in relation to the positionality of the researcher in Chapter 4. These limitations have been addressed, firstly by the use of an iterative interviewing method, in that each participant was interviewed twice and so interview data was checked with the participant to ensure accuracy. Thirdly, as described in Chapter 4, only four mentors were interviewed out of the targeted six, which will result in a less in-depth perspective of the mentor's role in this study.

Finally, the document analysis of the NMC documents provided insight into the policy and position of the NMC in relation to disability. However, Robson (2011) and Bickman and Rog (1998) argued on the accuracy of documents in research. Despite their value in this study of presenting insight into the NMC's position on disability, the use of interviews with a member of the NMC, who was directly involved in disability policy might have provided a more in-depth perspective in this specific part of the study.

### **9.3 Implications of the Theoretical Framework for Future Practice**

In Chapter 8 I described the design and influences of my theoretical framework, the Adult Dyslexia Framework (ADF) and its use for future research in this area. This study has considered research in a number of settings, namely universities and clinical placement areas. These settings were discussed in Chapter 3 of the literature review in the context of dyslexia. Universities or HEIs provide professional healthcare courses across a range of disciplines including paramedic science, physiotherapy, occupational therapy and radiology and in Chapter 1, in discussing the contribution of my study I stated one of my aims was to bring about a greater understanding of dyslexia amongst these HE professional healthcare groups. In comparison to nursing, it can be surmised that such disciplines would have a percentage of students with dyslexia on their

courses, considering the increasing numbers of students entering HE with dyslexia highlighted in Chapter 3, where specific learning difficulties such as dyslexia consistently make up around half of all self-reported disabilities in HE (HEFCE 2016). Despite these healthcare disciplines being based at universities, all will require clinical placements through the duration of their course; therefore, areas such as ambulance stations, clinics, nursing homes and specialist care centres all might at some point receive a healthcare student with dyslexia.

Similarly, the clinical competence of students in these healthcare disciplines is an important aspect of their practice according to the same professional regulatory standards of nursing, but rather the regulatory standards of the Health and Care Professionals Council (HCPC). Additionally, the competence standard, described in Chapter 2 as an 'academic, medical or other standard applied for the purposes of determining whether or not a person has a particular level of competence or ability' (Equality Act 2010) still applies in the same way to healthcare students with a disability, in that reasonable adjustments can be made to the way this competence is assessed, rather than the competence itself. Additionally in assessing a competence standard, this needs to be balanced with the professional responsibilities and standards of the NMC or HCPC, which were analysed and discussed in Chapters 6 and 7, specifically in relation to key NMC documents. In this context of similarities across healthcare disciplines, the adapted use of the ADF could be adopted for students with dyslexia across a range of professional disciplines and employment settings.

As this is a broad study across a number of professional disciplines in nursing from nurse to registered nurse, to tutor, mentor and preceptor, it has limitations in not having

an in-depth focus upon one singular discipline. In this context, the ADF would allow for a greater in-depth focus across a singular nursing discipline or branch of nursing such as paediatric, mental health or learning disability. I outlined in Chapter 8 how the ADF could be adopted in such research, and provided test examples using nurse participants from my study. This demonstrated how a visual presentation of the voices of each participant can be seen in the context of their experiences through both school and workplace.

## **9.4 Research Questions**

This section will consider the research questions outlined at the end of Chapter 3.

### **RQ1a. What do nursing students with dyslexia think influences and shapes their professional and educational experiences in clinical practice?**

The question focused on a number of areas of influences in relation to the nursing students' professional and educational experiences. Firstly, the school experiences of each of the students appeared to have a personal impact with both contrasting positive and negative experiences. As detailed in Chapters 5 and 7, Lucy, Olivia and Marie received their diagnosis of dyslexia whilst at school. Lucy and Marie spoke of an overall positive experience where support from teachers was evident. However, Olivia described a less positive experience, speaking of her frustrations and how she hated 'being different'. Glazzard (2010) and Madriaga (2007) claimed that when children receive an early diagnosis of dyslexia, they are given a reason for the difficulties they experience and as a result, become more confident in their own abilities. However, this did not appear to be the case for Olivia, whose dislike of 'being different', her frustrations of time away from friends and her feeling of being marginalised because

of her dyslexia have been reported as a common feeling amongst school pupils with dyslexia (Hughes & Dawson 1995; McNulty 2003; Ingesson 2007). Hall (2009) drew attention to the fact that teachers have a duty to identify any barriers to a child's learning under the SEN Code of Practice (DfES 2001). Frith (1995) spoke of the individual variability of dyslexia in relation to external influences such as age, sex, ability, motivation, personality and social support. Therefore, this suggests how support at school for a person with dyslexia can be perceived differently from one person to another.

In contrast, Emma, Holly and Chloe, who received their dyslexia diagnosis as adults, each had very different school experiences. Each spoke of their frustrations at school, in particular Emma spoke of her anger that her dyslexia was not picked up at school. Holly also spoke of her frustrations at school, describing lack of interest by teachers and a feeling of 'just going downhill'. Chloe similarly spoke of her difficulties at school, and of getting information from her head to paper... It is apparent that the students who received their diagnosis at school had a more positive and supportive experience, apart from Olivia, which challenges some of the research that suggests children who receive their dyslexia diagnosis at school become more confident in their abilities (Glazzard 2010; Madriaga 2007). This adds to the discussions in Chapters 2 and 7 of the evidence of a variable and individual presentation of dyslexia.

In respect of the educational and professional experiences in clinical practice, the study focused specifically on three clinical skills: documentation, drug administration and clinical handovers as highlighted in the development of the interview questions in Chapter 4. Each nursing student was asked specifically about these three skills

outlined in the nursing student interview questions (Appendix 11). Each of these will be summarised in turn in relation to the findings and discussion in Chapters 5 and 7.

With regard to drug administration, a number of the students, Emma, Holly and Lucy, all stated they needed to check, double check or triple check drugs prior to administration, giving reasons for this action as a fear of making a drug error. This strategy has been recounted in a number of other studies that have explored dyslexia amongst nursing students (Morris & Turnbull 2006; White 2007; Ridley 2011; Crouch 2017). This systematic approach to checking is a need to not only reduce the risk of drug errors, but also to show themselves in a more positive light to others, thus reducing their conscious stigma of dyslexia. McNulty (2003), Scott (2004) and Alexander-Passe (2015) agreed that dyslexics camouflage their difficulties with advanced coping strategies, so a sense of normality can be projected. In White's (2007) study, she described how nursing students with dyslexia would use such strategies to show themselves in a more positive light. Early work by Goffman (1959) spoke of impression management as the effort or control to influence others people's perceptions of you. Later work by Kuzmics (1991) speaks of the construction of 'fronts' and the threat of being caught in embarrassing situations is a 'human constant'.

Regarding documentation, each student spoke about particular and common difficulties surrounding documentation, such as getting notes down quickly enough and needing a quiet area to write. Similar difficulties with documentation amongst nursing students with dyslexia have been reported in a number of studies (Sanderson-Mann and McCandless 2005; Morris and Turnbull 2006; White 2007; Ridley 2011; Crouch 2017). Additionally, Illingworth (2005) spoke of a fear of being stigmatised amongst

nurses and health care assistants (HCA) with dyslexia, particularly because of spellings and writing problems.

With regard to clinical handovers, the fear and embarrassment evident in the questioning surrounding documentation was also apparent when the students were questioned about clinical handovers. Fears, such as speaking aloud and concerns of what others were thinking of them were common responses. Olivia openly admitted she had purposely avoided handover as a nursing student, a strategy of avoidance also highlighted by Morris and Turnbull (2006) and White (2007). Emma spoke of her difficulty keeping up in handovers and the embarrassment of having to stop the handover and ask what has been said.

The embarrassment and fear expressed by many of the nursing students, which became increasingly apparent across these three skills, was also apparent in reasons for a reluctance to disclose their dyslexia. Fears amongst the students about disclosure was a fear of being seen as 'stupid' or 'thick' and for some, the personality of the mentor greatly influenced a decision to disclose. Disclosure of dyslexia for the students in this study appeared to be influenced by a fear of ridicule or being marginalised because of their dyslexia. Lucy and Chloe said that the personality of the mentor influenced disclosure, particularly if they came across as 'mean or horrible', highlighted by Chloe. Emma spoke of her fear of disclosing for fear of being seen of someone with a low IQ. Similar fears about disclosure of dyslexia amongst nursing students are also apparent in a number of studies (Illingworth 2005; Morris and Turnbull 2006a, 2006b; White 2007; Ridley 2011; Crouch 2017).

The self-perceptions of the students further reinforced a concept of stigma and dyslexia. All the students spoke of their thoughts of what they fear others might be thinking of them, to a lesser or greater degree. A number of the students spoke of their perception or embarrassment of others thinking they were 'thick' or 'stupid', 'thinking I'm an idiot'. Dyslexia can affect perceptions of intellectual ability and academic competence in adulthood (Boetsch et al. 1996). There was no evidence that anyone had made such comments to them directly, rather this appeared to be their own self-perception. This negative self-perception expressed by the students can be described as self-stigma, defined as, 'an internal process whereby people judge themselves based on messages received from societal norms' (Almeida 2012: 90).

It has been highlighted on a number of occasions throughout this thesis, society places great emphasis upon literacy and places high value upon it as a key to education and subsequent academic success (Snowling 2000; Burden 2008). Therefore, is this just one possible cause as to why the students expressed this negative perception of themselves? It is difficult to determine a causation of self-stigma, but the evidence of the self-stigma described provides a conjectural insight into this notion.

A number of comparative studies highlighted in Chapters 5 and 7 compared the difficulties associated with dyslexia with a sample of dyslexic nursing students and non-dyslexic nursing students (Price and Gale 2006; Sanderson-Mann et al. 2012). These studies noted some non-dyslexic students experienced the same or similar difficulties, such as pronunciation of drug names and difficulty in drug calculations, documentation and clinical handovers. It is argued to what degree do such difficulties differ between a dyslexic and non-dyslexic nursing student in practice?

**RQ1b How might these influences and experiences change/be changed as they adapt and learn to work as a registered nurse with dyslexia?**

One key focus of this part of the study was whether anything had changed since becoming registered nurses, as well as a further focus upon the three clinical skills of documentation, drug administration and clinical handover. As previously highlighted in Chapters 3 and 5, there is limited research on the experiences of registered nurses with dyslexia, with currently only three studies evident (Illingworth 2005; Morris & Turnbull 2007b; Major 2017).

The nurses' responses to the above question varied. Emma spoke of how the support system she had at university had been 'whipped away'. Similarly, Marie commented that the support at university was no longer there and there was no longer help for her needs as a nurse with dyslexia. Morris and Turnbull (2007b) reported in the findings of their study, which explored the impact of dyslexia on career progression of registered nurses, that a large number of respondents reported receiving no support in the workplace at all. Illingworth (2005) reported in her study, which explored the effects of dyslexia on the work of nurses and healthcare assistants, that participants recognised a need for specialist help, without which, people may fail to reach their full potential.

In contrast, Holly, Olivia and Lucy felt nothing had changed much at all since registration, Holly spoke of how she had grown in confidence and had become familiar with the routine and how it had become less stressful. Lucy stated that 'nothing has changed' and further commented that her dyslexia 'doesn't bother me anymore'. Olivia similarly commented that nothing had changed and that others were 'alright about my dyslexia and have no worries or concerns'. Morris and Turnbull (2007b) reported that

58.6% (n=68) of the nurse participants had the majority of support from colleagues alone. Major (2017) commented that many of the nurse participants received support from both colleagues and managers. Chloe commented that it had become 'a bit easier now nobody's looking over my shoulder', indicating that she now felt she was under less surveillance as a registered nurse.

With regard to documentation, a number of the nurses still expressed difficulty with aspects of documentation, including difficulties with spelling and a need for a quiet area to write. Illingworth (2005) reported a number of participants in her study found writing patient records or filling in forms challenging. Emma and Holly both commented they took more time over their documentation, with Emma further commenting 'I'm usually the last to leave the shift'. Major (2017) reported that a number of nurse participants in her study commented they also took more time over their documentation and described an incident where a nurse participant was challenged over a spelling of an antibiotic.

With regard to drug administration, Lucy, Emma and Holly reported they continue double or triple checking prior to drug administration as they did when they were students. Emma further described how the first time she performed the drug round on her own was 'absolutely petrifying'; Olivia also commented she had 'never been so paranoid in all her life', with all citing the risk of error for adopting and continuing this strategy. Morris and Turnbull (2007b) also reported double or triple checking of drugs by the nurses in their study, with patient safety as a reason for this strategy.

With regard to clinical handovers, Marie, Holly and Emma spoke of their fear or embarrassment of handovers, particularly reading aloud in front of others and

pronunciation of particular words; this was unchanged since they were nursing students. Others felt little had changed with handovers. Challenges with handovers amongst nursing students with dyslexia were reported in two studies (Price and Gale 2006; Sanderson-Mann et al. 2012).

A number of the nurses still spoke of a reluctance to disclose their dyslexia as registered nurses. Olivia, Holly and Chloe all commented they would 'only disclose if I have to' or 'if appropriate' citing fear of others' negative reactions. Marie stated she would 'tend to keep it to myself' but commented if the mentor is approachable, she would disclose. Illingworth (2005), Morris and Turnbull (2007a) and Major (2017) all reported an unwillingness to disclose amongst a number of their nurse participants, for fear of being misjudged. However, Lucy was more than happy to disclose, commenting 'it's not important, they know who I am'.

Disclosure was linked to the nurses' self-perceptions in this study in that many expressed embarrassment of what others might think of them because of their dyslexia. Marie spoke of feeling a burden to others; Chloe spoke of 'just another thing to make you stand out as not normal'. Emma described how she felt trapped in her dyslexia. Major (2017) identified that the nurses in her study recognised the impact of a diagnosis of dyslexia and how it impacted on their sense of self. Therefore, does the fear and embarrassment expressed by the nurses of how others might perceive them reflect societies norms of literacy associated with dyslexia?

However, in contrast, Holly and Lucy were more accepting of their dyslexia, with Lucy stating, 'it doesn't bother me anymore' and Holly stating it was 'all behind me, not a big issue anymore'. Hellendoorn and Ruijssenaars (2000) argued that this acceptance of

dyslexia was from those who had had more positive experiences in their elementary school period and were more likely to accept their dyslexia as part of life. However, as highlighted earlier, Holly did not have a positive school experience; therefore, this theory might not always apply. Evans (2014a: 368), who explored identity constructions amongst nursing students with dyslexia spoke of students who embraced the dyslexia identity and appeared to refuse to internalise negative constructions of their dyslexic identity and, furthermore, were not preoccupied with how they were viewed by others. Rowlands et al. (2013) illustrated that familiarity with a specific learning difficulty (SpLD) can lead to a student's full acceptance of the diagnosis, which Holly and Lucy appear to have done.

In summary, the changes from nursing student to registered nurse are quite variable, but in other respects, there is little evident change. Some of the nurses still speak of their reluctance to disclose, a fear and embarrassment of what others may be thinking of them, some using language such as 'they think I'm thick or stupid', suggesting a self-stigma amongst these students. This is evident through transition from nursing student to registered nurse. In contrast, two of the nurses (Lucy and Holly) speak of their acceptance of dyslexia. However, Holly still expresses some reluctance to disclose her dyslexia. With regard to documentation, drug administration and clinical handovers, there remain some of the same strategies adopted as students.

Self-stigma is also evident in the reasons given for the strategies adopted, almost as a 'fail-safe' to reduce the risk of errors, such as double checking of drugs, taking time over documentation and checking the meanings of words prior to giving handover to not be shown in a negative light. The use of these strategies have all been highlighted

in a number of studies that have explored dyslexia amongst nursing students and nurses, and many of these have also spoken of the reluctance to disclose for fear of ridicule (Morris and Turnbull 2006, 2007a; Price and Gale 2006; White 2007; Ridley 2011; Crouch 2017; Major 2017). However, the evidence of self-stigma amongst the participants has not been as apparent as in this study. Evans (2013) noted that captured in his study was an evident link in the public mind between 'being stupid' and a 'dyslexic identity', describing this as the 'stupid discourse', which has an impact on student participation in nurse education. Therefore, in light of the findings of this study of this self-stigma amongst some of the nurses, is the 'stupid discourse' Evans (2013) spoke of, also evident in the voices and experiences of the participants in this study?

The work by Krammer (1974) in a US study, used the term 'reality shock' to describe newly qualified graduate nurses' experience of specific work settings where they felt inadequately prepared, as highlighted in Chapter 7. Later UK research supported this notion, and adopted the term 'reality stress' (Vaughan 1980; Walker 1986; Humphries 1987; Lathlean 1987; Gerrish 1990, 2000). In respect of this phenomenon, it is argued to what extent are the difficulties and some of the anxieties expressed by the nurses in this study caused by this 'reality stress' or their dyslexia? A number of comparative studies (Price and Gale 2006; Crouch 2010; Sanderson-Mann et al. 2012, Crouch 2010) have compared the clinical experiences of dyslexic nursing students and non-dyslexic students, and reported similar difficulties between the two samples. There remains a stronger literacy difficulty amongst the dyslexic participants in these studies. However, the presence of this 'reality stress' phenomenon and a number of similar difficulties identified in the studies by Price and Gale (2006), Crouch (2010) and

Sanderson-Mann et al. (2012) do support a need for further comparative studies in this area of study.

**RQ2 What are the perceptions, experiences and understandings of dyslexia amongst mentors, nurse tutors and preceptors who support and guide dyslexic nursing students/nurses through education and clinical practice both at pre-registration and post-registration level?**

The secondary part of this study explored research questions 2, the perceptions, understandings and experiences of nurse mentors, tutors and preceptors. This revealed different ranges of understanding amongst these groups. The mentors' range of knowledge of dyslexia was generally relatively basic with a focus upon basic literacy difficulties, specifically reading and writing. However, with reference to the dyslexia definition from Rose (2009) highlighted in Chapter 2, there is strong emphasis upon the literacy difficulty associated with dyslexia; therefore, it is argued that those who have lesser contact with individuals with dyslexia, identify dyslexia with difficulties in aspects of literacy. Fitzgibbon and O'Connor (2002) stated that dyslexia is now part of everyday language, but argued even though the word is well known it is often misunderstood.

In contrast, the tutors' understanding of dyslexia was more advanced with a focus upon different types and forms of dyslexia and how these different types can affect a person. The preceptors' understanding, similar to the mentors, focused mainly upon literacy difficulties, but with more specific mention of getting letters mixed up. However, preceptor 3C simply stated, 'they can't spell', but admitted she did not know much about dyslexia.

Evidence of a lack of understanding about dyslexia amongst nurse mentors was noted by Morris and Turnbull (2006), White (2007) and Ridley (2011). Sanderson-Mann et al. (2012) noted that only two out of 51 lecturer practitioners had knowingly mentored a student with dyslexia, and further noted that their knowledge of living with dyslexia was limited. Additionally, one study, which explored the perspectives of nurse tutors towards dyslexic nursing students (Evans 2014b), noted a variation amongst the nurse lecturers on their understanding of what dyslexia was and with similar findings to my study, the discussion of mild or severe forms of dyslexia. In summary, there was a range of knowledge of dyslexia amongst these groups. A number of studies noted that university academic staff seemed to have a lack of knowledge or understanding of dyslexia, or had not been trained (Tinklin and Hall 1999; Holloway 2001; Morgan 2001; Palfreman-Kay 2001; Mortimore and Crozier 2006; Riddell and Weedon 2006; Hanafin et al. 2007).

Significantly, all the mentors reported they could recall no inclusion of dyslexia on mentor training courses. Additionally, the NMC (2015a: 18) standards for mentors, practice teachers and teachers states, 'The NMC advises that all mentors, practice teachers and teachers should receive disability equality training.' The findings from this study clearly indicate this was not the case for the mentors in this study. This collective evidence suggests a need for an increased awareness of dyslexia amongst these groups through both training and in-service education, as well as an increased dialogue between universities and practice areas surrounding support of students with disabilities.

The perceptions of dyslexia amongst all groups were again different, with some demonstrating their open support for nursing students with dyslexia, with comments such as, 'no real concerns', 'done really well'. This positive support from mentors towards dyslexic nursing students was evident in a number of studies (Morris and Turnbull 2006; White 2007; Ridley 2011). However, in contrast, one particular mentor (2B) was quite openly negative about her perception of a nurse with dyslexia stating concerns for the patient as well as claiming she 'wouldn't want her looking after me', making a direct link to patient safety and the dyslexic nurse. Price and Gale (2006) reported negative comments, thoughtless remarks or public embarrassment were sometimes used by mentors. Patient safety was also alluded to by mentor 4D, who expressed concern about a dyslexic student giving a wrong drug. Sanderson-Mann et al. (2012) reported that some practitioner-lecturers raised the issue of ensuring students are competent to practise and the issue of patient safety.

The tutors perceived an openly supportive approach to dyslexic students, some claiming 'it shouldn't hold them back' and some commenting on the impact of dyslexia and its significant affect upon individuals. However, tutor 2B commented that dyslexia should not be used as an excuse to continue further on a nursing course and that dyslexics can be compared to non-dyslexic nurses in that some are more able than others. However, she did add a further comment that she would not know some nurses were dyslexic. This supports the findings of Sanderson-Mann et al. (2012) who commented that lecturer practitioners would have difficulty recognising a student with dyslexia and it would depend upon the quality of the working relationship. Evans (2014b) noted from his study, which explored nurse lecturers' constructions of dyslexia,

that a theme of 'getting the job done' was identified, which suggested that students with dyslexia were looked upon disapprovingly by some lecturers.

The preceptors demonstrated an understanding supportive approach with two (preceptors 5E & 6F) commenting they had changed their overall perception of dyslexia in a more positive, understanding way. This shift in their perceptions of dyslexia is interesting and there is no previous evidence of this in other studies that have explored the experiences of nursing students/nurses with dyslexia and/or mentors. Campbell et al. (2003) noted a shift in attitudes towards people with learning disabilities amongst trainee teachers using information-based instructions and fieldwork experiences. This evidence appeared to match preceptor 2B's experience, who described society's generic negative view of disabilities and how her approach to disabilities were influenced by a previous career working with people with learning disabilities. Preceptor 3C commented she was surprised her nurse was dyslexia as she was coping. This comment indicates a preconceived assumption that a person with dyslexia would have trouble coping within a work environment.

The tutor, mentors and preceptors' experiences described time with their individual nurse who participated in the study unless otherwise indicated. Generally, there was an indication of support as well as praise for their students/nurses' abilities. However, there were also feelings of concern amongst some. Mentor 2B recalled how she commented on some written work from her student, not aware she was dyslexic at the time, stating 'you're either stupid or dyslexic!' and further commented she was surprised she was pursuing nursing. These comments might be interpreted as discriminatory in nature and indicated a clear negative perception of nurses with

dyslexia. Price and Gale (2006) uncovered evidence of disability discrimination in her study usually resulting, as she described, from ignorance or little knowledge of the impact of dyslexia. Mentor 4D commented how she would have kept an extra eye on her student if she had realised she was dyslexic. These perceptions described might be interpreted as a tension between, on the one hand a duty of care to patients and the on other, the legal requirement to support students with dyslexia in practice (Evans 2014a: 43). Price and Gale (2006) described the conflict and challenge where whatever learning model emerges in a clinical practice environment, the principle of danger versus safety must be given due consideration.

In contrast, other mentors spoke of how the experience helped them understand more about dyslexia, some not knowingly aware that their students were dyslexic until later into the placement. Some of the tutors spoke of how they relied on what the students told them about their dyslexia to enable them to support them. Others commented, 'it was a bit tricky' and an expectation of a 'heavy need for support' in describing their experiences and approach. Major (2017) commented that seven out of nine nurse lecturers identified supporting students with dyslexia required extra time and effort. Some of the preceptors commented on their nurses' difficulties, with one noting they would have to be extra aware; another commenting that dyslexia is 'a problem if they don't tell us'.

However, there was also evidence of a preconceived assumption about the abilities of a nurse with dyslexia amongst the preceptors; preceptor 3C stated, 'wouldn't know she's dyslexic, doing very well'. Also, preceptor 2B commented, 'she didn't come over as dyslexic, she was very confident'. This suggests that the two preceptors perceived

an individual with dyslexia would have lower ability and confidence. These responses indicate evidence of a stigma, in that there was an assumption by the two preceptors that if you have dyslexia, you should just expect difficulties or problems. These assumptions can be related to 'disabilism', highlighted in Chapter 2, derived from the social model of disability whereby everyday practices of society members, including those in education, may perpetuate oppressive structures upon those who identify or who are categorised as being disabled (Madriaga 2007). Evans (2014b) described anticipatory judgments of a student's performance by some nurse lecturers in his study.

In summary, there is clearly evidence of support and an understanding of dyslexia amongst the three groups, but also evidence of stigma, or an assumption of difficulty or an anticipation of a problem in a nursing student or nurse with dyslexia. There is evidence of a shift in attitudes amongst some of the preceptors in this study towards nurses with dyslexia. What is apparent amongst some of the mentors, preceptors and tutors is a tension between support for students and patient safety. Therefore, there is a need to increase awareness of dyslexia through both education and experience in clinical practice.

This section considers RQ3a and RQ3b with regard to the professional position of the NMC in relation to dyslexia and nursing and nurse education and relates to the analysis and discussion of the three NMC documents at the end of Chapter 7.

**RQ3a What is the professional position of the Nursing and Midwifery Council (NMC) surrounding dyslexia in nursing and nurse education?**

The aims of the NMC are clearly stated both on their website and in the documents analysed in this study that is the protection of the public and patients and the registration of the nursing and midwifery professions. In consideration of the position of the NMC to dyslexia, firstly dyslexia is not mentioned directly, but comes under the collective 'umbrella' of disabilities mentioned in all three of these documents. Dyslexia is legally a disability under the Equality Act (2010). All three documents provide guidance for those who have either a health condition or disability who either plan to enter nursing or midwifery or are already in either of these professions and have developed a health condition or disability. The professional position in these documents are twofold: firstly, safety and fitness for practice, but at the same time meeting the legislative requirements of the Equality Act (2010). The documents place great emphasis upon patient safety and fitness for practice, but at the same time provide guidance to those with either a health condition or disability. The term 'safe and effective practice' is quite prominent in statements describing the standards to follow if a registrant has a health condition or disability. Evans (2014b) spoke of tensions between duty of care to patients and the legal requirement to support students with dyslexia with regard to the differing perceptions of mentors in practice, highlighted in the previous section. A similar tension exists in these documents; the NMC's professional position of protecting patients and the public but also to meet the legislative requirements of the Equality Act (2010).

**RQ3b How is the professional position presented through the NMC's national standard and guideline documents?**

The professional position of the NMC is presented through a series of statements and guidelines throughout the three documents. What is apparent throughout the documents is the use of language, in particular in the protection of the public or the wellbeing of the public or to safeguard the public, which is particularly evident in the *Character and health decision-making guidance* (2015). Other documents refer to 'fitness to practice' (NMC 2016c) or safe and effective practice without supervision. The three documents all provide clear guidance for registrants or potential students as to the process to follow if they have a health condition or disability. However, the underlying theme running through these three documents is the protection and safety of the public. The language described might be interpreted as discourses, as highlighted in Chapter 3, and defined as, 'written or spoken communication or debate' (New Oxford Dictionary 2001: 527). Despite meeting the legislative requirements of the Equality Act (2010) through providing guidance and ensuring fairness and equality in the process, the professional position or the values of the NMC are clearly stated, that is the protection and safety of the public.

## **9.5 Confidence in Research Findings**

Any research study should address the confidence in its findings. Internal validity is the extent to which the findings of a study are true and whether they accurately reflect the aims of the research as well as the social reality of those participating in it (Holloway and Wheeler 2002). It was briefly highlighted in the limitations section of the use of iterative interviewing and how this specific method is of value in checking with the participant what was said in the first interview when meeting for the second interview. This particular method can be seen as one form of member checking, where each participant is asked to confirm the accuracy of collected research data specific to

themselves. This method had not only the advantage of confirming accuracy of the data, but also allowed for accessing rich data or the drill-deep philosophy characteristic of case study research (Thomas 2011).

Validity in case study research, it is argued by Thomas (2011), is less meaningful. It has been highlighted in Chapter 4 that the purpose of case study is not in any way to generalise, rather the purpose is to provide an insight or to open up further debate. However, for the specific purposes of an academic driven research project such as this, a demonstration of a due research process should be followed which shows systematic steps have been taken through the collection and systematic analysis of the research data. The systematic process of this study is demonstrated in the discussion of the step-by step-processes of the analysis of the data in Chapters 5 and 6. This specific process can relate to rigour, which refers to the thoroughness of the study. Smith et al. (2009: 181) referred to rigour in the context of IPA, the method of analysis adopted for this study and speak 'in terms of the appropriateness of the sample to the question in hand, the quality of the interview and the completeness of the analysis undertaken'. This is demonstrated through the inclusion criteria for the each specific group of participants in this study in relation to the research questions outlined at the end of Chapter 3. These research questions are aligned to the interview questions for each participant group (Appendix 11-15) and direct links are made to the interview questions through the development of these in Chapter 4.

Additionally, the completeness of the analysis undertaken is demonstrated through the figurative representations of the direct voices and responses of the participants in Chapters 5 and 6. As this study was a longitudinal study where the researcher was meeting the nursing student/registered nurse participants over an extended period of

approximately 12 months, it is argued a relationship of trust was built up during this period, thus the interviewer effect is lessened (Hammersley and Atkinson 1995), which may further enhance the responses and discussions from the participants in contrast to an interview on one occasion only.

Overall, this study has made a specific contribution to knowledge surrounding the nurse with dyslexia in practice through the in-depth interview process, the drill-deep philosophy associated with case study as well as the longitudinal element of this study, which have added further to the limited body of knowledge of the registered nurse with dyslexia

## **9.6 Recommendations for Future Research**

This study has considered a number of areas of research surrounding the topic of dyslexia and nursing including experiences, understandings and perceptions of dyslexia. However, during the process of this study, a number of considerations of a need for further research in aspects of this topic have been alluded to. This section outlines areas where further research is needed in light of the findings of my study.

In Chapter 7, in the discussion of the findings, a number of comparable studies that explored two comparable groups of dyslexic and non-dyslexic nursing student groups were highlighted (Price and Gale 2006; Sanderson-Mann et al. 2012; Crouch 2010). The findings of these studies reported similarities in the difficulties experienced in clinical practice in relation to documentation, pronunciation of drug names and aspects of clinical handovers across both groups. This may suggest a blurring of the boundaries of the difficulties associated with dyslexia, or whether there is a percentage of undiagnosed dyslexics amongst these samples. In light of these findings, there is a

need for further studies of comparable dyslexic and non-dyslexic groups, which will add further research to this limited body of work.

The limited amount of research that has explored the experiences of the registered nurse with dyslexia (Illingworth 20005; Morris and Turnbull 2007b; Major 2017) was highlighted in Chapter 3. The findings of my study have shown a number of the registered nurses still experience difficulty with aspects of clinical skills and many experience concerns over disclosure of dyslexia, as well as evidence of a self-stigma: an inner concern of how others might perceive them because of their dyslexia. Therefore, there is a need for further research of the registered nurse with dyslexia to determine the impact of dyslexia post-nursing registration.

In Chapter 5 and in the later discussion in Chapter 7, the findings of my study revealed a shift in attitudes towards a nurse with dyslexia from a number of preceptors who had supported them in practice. This was an interesting finding and suggests that in supporting a nurse with dyslexia, and thus through the possible influences of this experience, a shift in attitude towards dyslexia can occur. Furthermore, in light of the increasing numbers of students with dyslexia entering HE (HEFCE 2016), as well as the legislative requirements and potential influences of the Equality Act (2010), there is a need to explore possible shifts in attitude towards students and employees in workplace settings.

As highlighted in Chapter 3, there is limited research surrounding the perceptions of nurse lecturers towards nursing students with dyslexia. Currently Evans (2014b) and Major (2017) have only explored this area of study, which is exclusive to my own study. The findings of my study in Chapter 6 and later discussion in Chapter 7 revealed some

positive support for nursing students with dyslexia, but also some perceptions of potential risks. Therefore, in light of my own findings, there is a further need to research this particular group who play a significant role in the development of the nursing student. Similarly, as has been highlighted in Chapter 3, there is currently no research that appears to have considered the role of the preceptor in the support of the nurse with dyslexia. My findings have revealed varied levels of support, as well as limited understandings of the needs of the newly registered nurse with dyslexia, amongst some of the preceptors. Therefore, there is a need to increase this body of knowledge in this area.

My study is currently the only study that has taken a longitudinal view of the nursing student and registered nurse with dyslexia. The findings of my study reveal that some difficulties are still experienced post registration as well as a continued reluctance to disclose dyslexia to others, with evidence of a continued feeling of self-stigma amongst some of the nurses. However, in contrast, there is also evidence of an acceptance of dyslexia amongst some of the nurses as well as greater familiarity with nursing tasks. Therefore, there is a need for further longitudinal studies in this area, perhaps over a much longer timeframe than the 12 months that were considered in this study to measure the impact of dyslexia post nurse registration.

One particular revealing aspect of the findings of my study is the personal impact and feelings that have been generated by the nurses in this study. These personal feelings reveal the true personal impact of dyslexia on a number of the participants. As highlighted in Chapter 3, there remains a limited amount of research surrounding the

self-perception of dyslexia (Burden 2005) and in light of my findings there is a further need to explore this specific personal and intimate aspect of dyslexia.

All four mentors in this study reported they had received no disability training on their mentoring course. There was evidence of a lack of knowledge about dyslexia and the impact of dyslexia amongst a number of the mentors and preceptors. As stated earlier in this Chapter, a requirement of the NMC (2015a: 18), *Standards for Mentors, Practice Teachers and Teachers* states that all mentors should receive disability awareness training. Therefore, the long-term outcomes should be that both mentors and preceptors should receive a period of education or training on disabilities amongst nursing students and nurses, which it is hoped will increase the awareness and understanding of disabilities including dyslexia.

## **9.7 Final Thoughts**

My understanding of dyslexia has developed from a very basic knowledge at the time of my first contact with a student with dyslexia 16 years ago through to where I am now, completing a large-scale study on dyslexia in nursing and nurse education. What I can reflect upon is the significant personal impact dyslexia has upon a person and the difficulties they face, including negative attitudes from some, which reflect a lack of awareness and understanding rather than outright discrimination. There is a need for greater understanding of dyslexia, to embrace it, find out more about it, do not be afraid of it. Through my research, I hope I can simply enhance people's understanding of dyslexia and through understanding, ensure those who have it are better supported and better understood, and attempt to reduce the stigma of dyslexia that is still evident in the findings of my study.



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## APPENDIX 1: Nursing Students – Data Analysis Tables

Please note these are only a selection of the analysis tables. As this study generated a large amount of data, it was not possible to include all analysis tables.

### Initial Theme A for Case 1 – Nursing Students, Disclosure

#### Interview with Emma – Disclosure (Nursing Student)

<p><b><u>Emma Interview 1 Emma pp. 9/10</u></b></p> <p>BG After disclosing your dyslexia, have you ever received a strong reaction .....whether that’s positive or negative, either in practice or here at university, or anywhere else for that matter?</p> <p><b>Emma:</b></p> <p>I’ve had people when I’ve disclosed it say, “Do you know? I think that I’ve got a bit of that” When I have explained, you know, they have said “That’s quite common”, or if they know..., somebody knows somebody in their family who have got it, they totally understand, but <b>if it’s somebody who is...,doesn’t struggle in</b></p>	<p><i>Categorises reactions to disclosure between those who suspect they have elements of a dyslexic trait or family members who have it and then identifies those who don’t struggle academically and don’t understand it.</i></p> <p><u><i>Perception of linking dyslexia and academia or intelligence in what others may consider it as</i></u></p>	
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<p><b>any way academically, they don't seem to understand at all, I think they see me as a..., I don't know if this is my perception or if this is the vibe that they give off, but I think they see me as being of a lower IQ,</b> I don't think they realise that I have still got high intelligence, it's just the way that I process information and give my information, it..., it's just different.</p> <p><b>Emma</b></p> <p>.....and yeah, <b>I do think they see me as..., [Pauses], yeah, as daft [Chuckles].</b></p> <p>BG</p> <p>Have you ever received an outwardly negative reaction?</p> <p><b>Emma</b></p> <p>[Pauses], <b>no, I don't think I have, nobody has been obvious, [Long Pause], no.</b></p>	<p>Discussion of a perception from those who don't understand give off a vibe of her having a lower I.Q.</p> <p><u>Note, this hasn't being said to her, rather this is her perception of what others think of her, almost having a perceived inner feeling of what someone might be thinking of her because of her dyslexia in this case negatively</u></p> <p><i>Identifies herself as having high intelligence noting a different way she processes information – citing dyslexia as simply just being 'different'</i></p> <p><u>Use of the word 'daft', again a self – perception or inward thought of how others see her</u></p> <p>Clarification that she cannot recall ever receiving an outwardly negative reaction to her dyslexia</p>	<p>Negative self-perception from others of dyslexia</p>
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**Interview with Holly – Disclosure (Nursing Student)**

<p><b><u>Interview 1 Holly pp.17-18</u></b></p> <p>BG Do you make a point about that now, to disclose it, when you are on placement?</p> <p><b>Holly</b></p> <p><b>No, not really, but I kind of know when there's times when I need to.</b></p> <p>BG Yeah.</p> <p><b>Holly</b></p> <p><b>.....I think it's best to be upfront, because, if I'm not upfront, she might think, "Gosh, she's taking her time" or, "Is she having difficulty?" or, you know, "Is she...?" Just little things like that, but again, they're all fears from my point of view.</b></p> <p>BG Sure. But you say, not really, you don't really want to disclose it, what is your reason behind that, just people's reactions?</p> <p><b>Holly</b></p> <p><b>Just mainly people might think that you know, I'm not really...,maybe my abilities aren't going to be good enough to be a qualified nurse.</b></p>	<p>Reluctance to disclose, but identified occasions when there is a need to disclose</p> <p><i>Being 'upfront' or honest about her dyslexia appears to provide reasons for her difficulty rather than not disclosing and the fear of being seen as someone who is having difficulties without any reason for this.</i></p>	<p>Disclose dyslexia to prevent negative perceptions from others</p>
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<p><b>Holly</b></p> <p>Or maybe they're going to be thinking, "Well, perhaps she's not going to be safe doing this or that", whereas, I don't agree with that.</p>	<p><i><u>Fears about others perceptions of her abilities aren't going to be good enough to be a nurse again justifying reasons for her disclosure of dyslexia would provide others awareness of her dyslexia and associated difficulties</u></i></p>	
<p><b>Holly</b></p> <p>But, I don't know what some people's perception is, is that the right word? I don't know what...what some people's perceptions are going to be.</p>	<p><i>Stigma – does everyone associate dyslexia with difficulty – how might society construct this?</i></p> <p><i>Further fears of others negative perceptions, this time fear around others concerns around safety.</i></p>	<p>Fears of judgments from others of being a nurse with dyslexia</p>
<p><b>BG</b></p> <p>When it..., when it's come to a point where you have actually had to disclose it...?</p>	<p><i>Quick to establish her disagreement with concerns surrounding safety and the dyslexic nurse. Identifies an existing awareness that there are such concerns that exist – an awareness of societies view or again a stigma surrounding dyslexia</i></p>	
<p><b>Holly</b></p> <p>Yeah?</p> <p><b>BG</b> What were certain people's reactions? you said that you haven't had anything negative.</p>	<p><i>Fear of not knowing what others perception of dyslexia will be – identifies perhaps an inherent risk of disclosing dyslexia</i></p>	

<p><b>Holly</b> No.</p> <p>BG What do certain people say, what do..., do they question you, or...?</p> <p><b>Holly</b></p> <p>Well, uh...hm, some people will just go, you know, "Oh, oh, oh right" and that will be it, and uh...hm, I have had one person say to me in the past, "Well, how do you cope with that?".....my previous Mentor, and she was really good, and..., and then that's it, it's just left, it..., you know, not that I want to talk about it too much.</p> <p><b>But nobody else seems to bring it up, so, I'm hoping that's a good thing.</b></p>	<p>Discussion of differing reactions to dyslexia – note none of them negative so experience would indicate fears of disclosure are not due to personal experience, rather what she perceives what others <b>might</b> think of her</p> <p><i>Expression of an unwillingness of not wishing to talk about it much – <u>again perhaps for fear of a negative reaction</u></i></p> <p>Expressing relief that it's good no-one brings it up – again fear of reaction or explaining it to someone and perhaps indicating she would rather not disclose dyslexia anyway</p>	
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		<p>Fear of talking about her dyslexia to others</p>
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**Interview with Lucy – Disclosure (Nursing Student)**

<p><b>Interview 1 Lucy pp.24-26</b></p> <p>BG Onto the disclosing of dyslexia, have you ever received a particular strong reaction?</p> <p><b>Lucy</b></p> <p>No.</p> <p>BG No?</p>		
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<p><b>Lucy</b></p> <p>Some placements..., and there is some placements, <b>it depends where I am, and what the staff is like, I find that I don't feel very comfortable with them anyway, telling them that, and then I just don't feel comfortable with them.</b> I would say like that one placement, she didn't realise that I was until I told her, and she went "Oh hey, OK, are you alright though?" And I said, "Yeah, I will ask for help" And she said, "Well, you seem to be doing fine, and so I can't..., I can't notice it" And then that was it really, they never mentioned it again, they just said, "You know, if you need our help with the spelling and stuff..." That was it, but they've left me to do it.</p> <p>BG So you haven't had a negative reaction at all?</p> <p><b>Lucy</b></p> <p>No, I think that people ask about it, and understand about it a bit more.</p> <p>BG</p> <p>Yeah.</p>	<p><i><u>Feelings of how comfortable she feels with the staff in a particular placement area.</u></i></p> <p><i><u>Suggests a staff members approach and demeanour towards a student can influence quite strongly the decision to disclose</u></i></p> <p>Experience of when she did disclose, the reaction was not threatening or negative <u>suggesting were her initial fears surrounding disclosure realised</u></p> <p><i>Never mentioning it again and being 'left to It' suggests perhaps a sense of relief from the student that her dyslexia wasn't brought up again</i></p>	<p>Personality of mentor affects disclosure</p> <p>Actual dyslexia disclosure not threatening after all</p>
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	<p><i>The statement that they 'understand it a bit more' suggests the student views a progression of an improved understanding of dyslexia among people than what was previously the case</i></p>	
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**Interview with Olivia – Disclosure (Nursing Student)**

<p><b>Interview 1 Olivia pp17-19</b></p> <p>BG On disclosing your dyslexia, if you do disclose it, have you ever received a strong reaction to that, that you're dyslexic, that you felt was positive or negative? Now, that could be either in practice or at university.</p> <p><b>Olivia:</b> Both.</p> <p><b>Olivia:</b> Some of them are..., <b>most of them are OK, they're not negative or positive. I don't..., when you say you're dyslexic,</b></p>		<p>Lack of understanding</p>
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<p><b>they're aware of what dyslexia is, but they don't know how that impacts on what you're going to do or say, or how you react, or anything that you write.</b></p> <p>BG</p> <p>Mmm hmm.</p> <p><b>Olivia:</b> People, especially lecturers here, some of them are like, "Oh yes, yes yes, I get what that means, that's fine" some of them, "OK, yeah, I get what you mean, OK" and they just walk..., because they don't really understand it themselves, and so they walk off.</p> <p><b>Olivia: On practice-wise, I said I was dyslexic, and she goes, "Yes, and what does that mean?" and I was like, "OK..." I had to explain it then, [Chuckles], and I was like..."I have difficulty reading and writing and spelling and it's just a lot slower"</b></p> <p><b>Olivia</b></p> <p>And she was like, "Right..." "I don't know what else to say, [Chuckles], but that's just it"  <b>And then the other lady, she actually come up to me and then she..., "Oh, you're</b></p>	<p>Describes that people are aware of what dyslexia is, but comments further on their lack of understanding on the greater impact of dyslexia – <u>suggests a self-awareness of the deeper personal impact of dyslexia on her life and people's ignorance of this</u></p> <p>Again commenting on others awareness but this time lecturers understanding stating their 'I get what you mean' reaction but stating they don't really understand. <i>Suggests again lack of understanding of the greater impact of dyslexia by others</i></p> <p>Experience of actually disclosing dyslexia and having to provide an explanation to someone.  <u>Interesting the explanation was very brief and more summed up the classic literacy difficulties rather than an in-depth explanation</u></p> <p>Description of offering of support to her on from a nurse on disclosing her dyslexia, which</p>	<p>about impact of dyslexia by many</p>
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<p>dyslexic, aren't you?" and I was like, "Yes, yes" "No worries, if you've got any problems, if you've got any needs, anything, come to me, and I'll help you with the spelling, I'll just tell you anyway"</p> <p><u>Interview 1, Olivia, p.18</u></p> <p>BG: Is there <b>any reason why you don't wish to disclose your dyslexia?</b></p> <p><b>Olivia:</b> It avoids the people looking at you and going, [<i>Mimics a patronising and condescending tone of voice</i>] "Right, you're really struggling at reading, mmm?" And that..., that is so..., it's so..., I don't know how to explain that one.</p> <p><b>Olivia:</b> Ever since I was younger, people will look at me and go, "Oh, oh, you're a bit..." Because people still are assumed to be thick, you're a..., you're a bit stupid, or, "Well, why are you in university? you're really stupid..."</p>	<p>come across of someone being very supportive</p> <p>Provides explanation what she might not disclose her dyslexia because of others perceptions of her and sympathetic reaction and perception of her struggling</p> <p>Reflects when she was younger of people's assumption that you must be thick or stupid and perhaps question why she was at university</p> <p><u>Clearly very conscious of others negative perception of her which strongly influences disclosure</u></p>	<p>Disclosure influenced by others negative perceptions</p>
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**Interview with Marie – Disclosure (Nursing Student)**

<p><u>Interview 1 Marie pp. 7-8</u></p> <p><b>Marie</b></p> <p>..., I told people that I did have dyslexia, I..., I kept..., I kept a lot in me, and when they asked me questions I did not know, I just tried to hide around it, kind of, but when I came out..., when I told my Tutor..., my Mentor, in Critical Care, she was a bit understanding, because she said she had the dyslexia as well.</p> <p>BG</p> <p>Sure.</p> <p><b>Marie</b></p> <p>And look at where she got.</p> <p>BG</p> <p>Sure.</p> <p><b>Marie</b></p>	<p><i>Initially tried to hide it – use of the term ‘when I came out’ is interesting to describe when she disclosed it. Term often associated with disclosing homosexuality, so she appears to associate her disclosure of dyslexia the revealing of a significant stigma in that sense is using this term</i></p> <p>Revealing mentor also disclosed her dyslexia which made disclosure positive in this circumstance,</p> <p><u><i>The mentor demonstrating that dyslexia was no barrier to her professional development</i></u></p>	<p>Mentor was dyslexia, made it easier – understood it more</p>
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<p>So, she motivated me to just speak out loud, whether the question might be wrong, I should just say it, because, they can only correct you.</p> <p><b><u>Interview 1, Marie p.18</u></b></p> <p>BG Is there any sort of reason why you don't want to tell them? Is there anything in yourself, you think, "Oh, I'd rather not tell them"?</p> <p><b>Marie</b></p> <p><b>Yeah, because I just feel like they'll feel, uh-hm, I'm not clever, I'm just..., I don't know, dumb, I don't know.</b></p> <p>BG</p> <p>Do you think people associate dyslexia with intelligence?</p> <p><b>Marie</b></p>	<p><u>Working with this mentor who disclosed her own dyslexia gave her motivation – the presence of another nurse with dyslexia appears to make a significant impact suggesting collective understanding of dyslexia</u></p> <p><u>Reason for non-disclosure is perception of others of being 'not clever' – association between dyslexia and intelligence</u></p> <p><u>Her feelings a lot of people associate dyslexia with intelligence, but awareness that perception isn't correct. This is despite her own</u></p>	
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<p>BG</p> <p>Yeah.</p> <p><b>Chloe</b></p> <p>And they say, “Oh, is there anything you want to tell us” and I’m like...“<b>Well, I’m dyslexic, but as long as you don’t make me..., laugh at my spelling...</b>”“<b>Then it shouldn’t really be an issue</b>” And it’s not usually, although..., but I’m not acutely aware of it when I’m on the wards.</p> <p><b>Chloe:</b></p> <p><b>I mean, with dyslexia..., with my dyslexia, it’s..., I don’t mind disclosing it particularly, I mean, unless I think the Mentor comes across as really kind of mean or horrible, sort of thing, [Chuckles].</b></p>	<p><i>impact of disclosure of her dyslexia to others</i></p> <p><i>Feeling she’s been quite lucky perhaps suggesting the awareness of the pitfalls of disclosing her dyslexia</i></p> <p><u>Revealing that on disclosing, was told others on the ward have it as well – this perhaps cushions the blow of disclosure</u></p> <p><i>Highlights won’t disclose if the mentor comes across as mean or horrible suggesting the personality</i></p>	<p>Making joke of having dyslexia</p> <p>Personality of mentor impacts on disclosure</p>
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	<p><i>of the mentor can strongly influence whether to disclose or not</i></p> <p>Describes that she doesn't mind disclosing it unless the mentor comes across as mean or horrible</p> <p><u>Clearly the personality of the mentor influences significantly if she discloses</u></p>	
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**Initial Theme C for Case 1 – Nursing Students, Drug Administration**

**Interview with Emma – Drug Administration (Nursing Student)**

<p><u>Interview 1, Emma p. 6,7</u></p> <p><b>Emma:</b> When it comes to <b>drug administration, I haven't had a problem, but I am extremely..., extremely paranoid, [Chuckles], and I would go over and check and check and check and check the drugs.</b></p> <p><i>BG Yeah.</i></p>	<p><i>Uses the term 'paranoid' to describe her strategy to check and check and check again to ensure she makes no mistake with drugs. Demonstrates her stark awareness of her difficulty.</i></p>	<p>Paranoia of checking and checking</p>
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<p><b>Emma:.....I would just go over and over and over it, because that is something that really, really scares me, you know.</b></p> <p><b><u>Interview 2, Emma p.24,25</u></b></p> <p><i>BG You mentioned about drug administration, you are actually extremely paranoid about it, tell me a bit more about that, you..., that you are paranoid about making an error, would that be correct, or...?</i></p> <p><b>Emma:</b> Yeah.....I think that because everything..., because you're aware that you can make mistakes...because you are told, you know, that that's what it is.</p> <p><b>Emma:</b></p> <p>So..., but yeah, so, it just makes me more extra vigilant, extra..., you know, I'll check and check and check.....and have those routines where I have to go through for every..., you know, medication, I go through my five R's, you know, making sure I've got the right route, and that, you know and everything. ....yeah, <b>it just makes me extra careful.</b></p>	<p>Highlights that the thought of making a drug error really scares her, suggesting this fear heightens her need to multiple check everything</p> <p><u>Making a direct reference to dyslexia in terms of doing something wrong with regard to drug administration</u></p> <p><u>Directly referring to dyslexia highlights how aware she is of her dyslexia in relation to her role and responsibility as a nurse</u></p> <p>Giving details of how she makes the process of check and check again, describing this as routines. Use of 5 R's strategy – right patient, right drug, right date, right time, right drug chart. Strategy used by non-dyslexic nurses as well, but clearly a</p>	<p>Great fear of making a drug error</p> <p>Dyslexia increases awareness of making errors</p>
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	<p>good aide memoire, not just making her careful, but extra careful</p> <p><i>Emphasis on extra careful, rather than just careful emphasises her caution over drug administration</i></p>	
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### Interview with Holly – Drug Administration (Nursing Student)

<p><b>Interview 1, Holly, p. 13,14</b></p> <p><i>BG What about drug administration?</i></p> <p><b>Holly: I will NEVER EVER guess it, I will go and seek advice, but if the handwriting is not clear, 9 times out of 10, it is not clear, you know, I do dread that, but I will ALWAYS seek advice beforehand, and what I do tend to find is that it does take me a little bit of time to find the correct drug.</b></p> <p><i>BG Yeah.</i></p> <p><b>Holly: I think it's probably the one area where I am probably going to take a lot more time than a nurse say that hasn't got dyslexia, because uhhh, you know, I'm constantly looking at it, I'm constantly checking it, or I'll go to the Kardex, I'll look</b></p>	<p>Highlighting her strong emphasis of NEVER EVER guess it as well as her fear or 'dread' that if the writing is not clear, but she would always seek advice</p> <p><u>Suggests an underlying fear of making an error.</u></p> <p><u>This demonstrates an awareness of her difficulties as well as awareness of the potential risk of a drug error if she doesn't seek advice.</u></p>	<p>Fear of making a drug error</p>
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<p>at it, and I'll look down at the box, and I..., I'll marry the two up, and then I'll look again [<i>Chuckles</i>], and then I'll do it again, uh-hm, and then again, you know, as you take the tablets out of the box, I'll check on the little strip, and I do the same thing again, and then uh-hm..., you know, it is..., it's just checking.</p> <p><i>BG Yeah.</i></p> <p><b>Holly:</b> Checking. Like the..., I am conscious that it takes quite a long time, I mean, not hugely, you know. I've got all morning, but... It takes that little bit longer.</p>	<p>Highlighting that as a result of her checking strategy, giving out drugs will take her longer contrasting herself against a nurse who does not have dyslexia.</p> <p><u>Perhaps here giving justification for why she takes longer.</u></p> <p>Giving further details of how she checks drugs and the different stages of this checking process. Providing this explanation demonstrates again her awareness of her difficulty as well as the significance of this very precise step by step checking can eliminate or certainly reduce the risk of a drug error</p>	<p>Constant checking of drugs takes me longer</p>
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**Interview with Lucy – Drug Administration (Nursing Student)**

<p><b><u>Interview 1, Lucy, p. 19-21</u></b></p> <p><b>Lucy: ....doing drugs don't bother me, it's trying to say some of the drugs, the names. To get right, because the way that I was reading it, it was not actually how you would pronounce it.</b></p> <p><i>BG OK.</i></p> <p><b>Lucy:</b> But I have learnt a LOT over my last 2 placements, how to say them, and learning about the effects of them, I have learned them, but it was actually just saying them out loud to somebody, just because I was worried that I would probably say them wrong or something.</p> <p><i>BG Sure.</i></p> <p><b>Lucy:</b> But that was just confidence, and gaining on it, and they said, "You just, you get used to them"</p> <p>BG Did you ever feel as if you were making an error drug administration?</p>	<p>Expressing difficulty in pronouncing drug names and contrasting the way she was reading them and how she would pronounce them highlighting a specific difficulty between reading and pronunciation</p> <p><u>Identifying a specific difficulty of actually not just saying them but saying them out loud to others and the worry of saying them wrong, perhaps heightening a fear of error</u></p> <p>Mention of confidence in aiding this ability to develop her knowledge of drugs and 'to get used to them'</p>	<p>Difficulty pronouncing drug names</p> <p>Fear of saying drug names out loud</p>
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<p><b>Lucy: No, no, because I always double check it, and make sure, I do it 3 times, and so I do always check them.</b></p>	<p><u>Would be of interest how this confidence develops post qualification</u></p> <p>Emphasis on double checking and doing it 3 times</p> <p><u>Re-iterates the importance to her of checking drugs to avoid an error</u></p>	<p>Always double and triple check drugs</p>
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## Interview with Olivia – Drug Administration (Nursing Student)

<p><b><u>Interview 1, Olivia, p. 15</u></b></p> <p><b>Olivia:</b> Drug Round on placement 1 is OK, because it is all computerised, and you can see spellings, you can see how it's formatted,</p> <p><b>Olivia:</b> Drug administration is not a problem, I am..., it's all..., because it's all black and white, there is no wrong or right about it, it's this much over this time, and that's what the prescription says, but the written one, over at the last placement, if I can't read, or if I don't understand it, I don't give it, but then that causes a drug error. Because anything omitted is a drug error.</p> <p><i>BG OK.</i></p> <p><b>Olivia:</b> So, my future job will be people..., places which have computerised systems</p> <p><b><u>Interview 2, Olivia, p. 52,53</u></b></p>	<p>Identified the ease of reading computerised text in contrast to written text, clearly easier for someone with dyslexia</p> <p><u>Details that drug administration not a problem, puts into context that there's no wrong or right about it – suggesting ease of understanding.</u></p> <p>However contrasts with the written word where she identifies specific difficulties that if she can't read or understand, she won't give it. But doing this becomes a drug error, therefore questions either she asks for advice in such circumstances.</p> <p>Highlights the advantage of computerised systems in her future employment as a nurse</p>	<p>Difficulties in reading written prescriptions</p>
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<p><i>BG So dyslexia, in terms of drug administration, does it cause you any concerns?</i></p> <p><b>Olivia:</b> No, because...because, most of the drugs, I know what they are.</p> <p><b>Olivia:</b> And I know what..., I have seen them so many times now, and now I know that this one is this, I know that this one is for epileptic, or this one is for nerve pain, and that's what they're having it for, and I wouldn't..., that is just from 3 years of being told it, "This is this, this is this, and this is this"</p>	<p>Highlight how familiarity makes drug administration a relatively worry free task, contrast to others who have expressed fear over making an error</p>	<p>Has become more familiar with frequent drugs</p>
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**Interview with Chloe – Drug Administration (Nursing Student)**

<p><u>Interview 1, Chloe, p. 16,17</u></p> <p><i>BG And drug administration?</i></p>		
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<p><b>Chloe: I have an issue with the boxes, you know where you have to put the date, and you have to tick it, and put your initials in it? I've really struggled to match the boxes up.</b></p> <p><b>Chloe:</b> So, I tend to..., I mean, obviously I don't sign them at the moment, because I'm a student, but, to make sure other people have, it takes me a while to bring them together, I have to use my fingers which makes people giggle.</p> <p><i>BG What about the drugs charts, do you..., when you're sort of actually giving out the drugs, do you match up everything OK?</i></p> <p><b>Chloe:</b> Yeah. I tend to find actually..., like, because obviously drugs are kind of..., you can't say half of them, and you can't..., you can't spell half of them. So that's easier. Because it's not a word I recognise or anything...It's easier for me to read.</p> <p>BG Yeah.</p>	<p>Highlights difficulty matching the drug on the chart with the date and where you should sign in the boxes. Clearly causes her visual difficulty not noted by the other students with dyslexia</p> <p><u>Notes that results in some amusement by other staff of her strategy, perhaps highlighting some staff's less accepting of a different strategy</u></p> <p><u>A little confusing what she actually means here in terms of 'can't say half of them and can't spell half of them, so that's easier' and because it's not a word she recognises, it's easier for her to read – a rather contradictory statement!</u></p>	<p>Difficulty in lining up boxes across chart</p>
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<p>BG Do you have no difficulties pronouncing them?</p> <p><b>Chloe:</b> Sometimes, [<i>Chuckles</i>].</p> <p><i>BG Sometimes?</i></p> <p><b>I just make them up, and people are like, “No, it’s not that, it’s this”</b></p> <p><b><u>Interview 2, Chloe, p. 36,37</u></b></p> <p><i>BG So you said, drugs are..., you can’t say half of them, and you can’t spell half of them.</i></p> <p><b>Chloe:</b> Yeah. But I don’t know, I think..., I think that’s the case with a lot of people, like I ..., I don’t really think that I’m particularly abnormal for that, because some of them have really stupid names.</p>	<p><u>Pronunciation declared as a problem sometimes and just making them up which appears to result in people helping her pronounce it properly, therefore assistance of others helps pronunciation difficulties</u></p> <p>Makes a comparison to others without dyslexia stating who have difficulty with drug names, she doesn’t think that she’s particularly abnormal.</p>	<p>Pronunciation of drug names a difficulty</p>
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<p><b>Chloe:</b> And if you don't know, I will just read it out to you, like spell it out, but as long as I can kind of match the bottles..., the label to the...to the script, I don't ..., it's not too bad.</p>	<p><u>Trying to perhaps perceive herself as a contrast between dyslexics and non-dyslexics terms of that dyslexics do have difficulty with drug names, but then so does everybody else, trying perhaps to reduce the stigma of dyslexia.</u></p> <p>States she will read it out or spell it out to counteract this difficulty and matches the bottle or label to the script identifying another strategy to overcome her difficulty, concluding it's not too bad.</p> <p><u>A development of strategies to assist her perhaps cushions the impact of dyslexia to her as a nurse</u></p>	<p>Non-dyslexic nurses have difficulty with drug pronunciation</p>
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**Interview with Marie – Drug Administration (Nursing Student)**

<p><u>Interview 1, Marie, p. 11,12</u></p> <p><i>BG So, drug administration...?</i></p> <p><b>Marie:</b> Yeah.</p>		
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<p>this drug for? What is that drug for?"</p> <p>If I know it, and I've learnt it, yeah, I know it.</p> <p>BG Yeah, yeah.</p> <p><b>Marie:</b> But when they go and say, "Go and read it up and come back" I can do that. But, it's just when the patients question you, "Why are you giving me this? Why...?" But obviously, since we did the exams, it's helped me a bit more.</p> <p>BG Right.</p> <p><b>Marie:</b> Knowing...what to say now, and what I am actually giving out, but before that, no, I just was...</p> <p><i>BG How about the actual procedures, the sort of checking the drugs?</i></p> <p><b>Marie:</b> Oh yeah, I'm fine with that.</p>	<p>Reiterates her difficulty is when been asked by patients what a drug is for. However stating if she knows and learn it, this is ok.</p> <p>Highlighted recent exams has helped her increase her knowledge over drugs</p> <p>Clarifying that she experiences no difficulty with checking the drugs in contrast to the other students</p>	
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## APPENDIX 2: Registered Nurses – Data Analysis Tables

### Theme A1 for Case 2 – Registered Nurses – Changes since becoming a registered nurse

#### Interview with Emma – Changes since becoming a registered nurse

<p><u>Interview 1, Emma, p.1.2</u></p> <p>BG To start off with, since you've become a Registered Nurse, do you feel anything has changed, or is anything different in relation to your dyslexia?</p> <p>Emma: [Pauses], I think it's very much down to me...I find that..., <b>that the support network I had at Uni...and, it's uh-hm, whipped away</b>, [Chuckles].</p> <p>BG Yeah</p> <p>Emma: I have..., I do have a person I can turn to, but in respect of dyslexia, it's I can turn to her for other things, but...but, there's not..., <b>there's nobody that's aware of, you know, my needs as a dyslexic...at all, no.</b></p>	<p><i>The term 'whipped away' very significant about the sudden loss of support that she once had as a student, describes a sudden disappearance of something that clearly had an impact</i></p>	<p>University support no longer there</p>
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<p>BG Not at all?</p> <p><b>Emma:</b> The paperwork has just changed at the minute...and we <b>just have to read and read and read and read, until I understand it, well I..., I just..., I just..., if someone could just show me...talk me through it once, that's all I'd need, and I'd know it...</b></p>	<p>Describes a lack of anyone that can really understand her needs as a dyslexic</p> <p>Gives an example where there is nobody around to support her in terms of new paperwork</p> <p><u>Almost a feeling of isolation here that she feels very much alone</u></p>	<p>No-body understands my needs</p> <p>Feeling of isolation</p>
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### Interview with Holly – Changes since becoming a registered nurse

<p><b><u>Interview 1, Holly, p.1</u></b></p> <p><i>BG To start off with, since you've become a registered Nurse, has anything changed, or anything different, in relation to your dyslexia?</i></p> <p><b>Holly:</b> no, not really.</p> <p><i>BG No?</i></p>		
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<p><b>Holly:</b> No, no, I'm just trying to think. I think I've probably grown in confidence.</p> <p><i>BG Right.</i></p> <p><b>Holly:</b> I think, knowing how the wards work...</p> <p><i>BG Yeah?</i></p> <p><b>Holly:</b> Knowing the procedures, the routine, I think that has..., is..., that's less stressful. So, you get into..., you get..., you get into a routine.</p>	<p>No change reported, however interesting mention of growing in confidence</p> <p>Describing knowing how the ward works certainly makes a difference</p> <p>Further description of knowing the procedures reduces stress as well as getting into a routine</p> <p><u>Noted confidence and routine can create an impact in terms of reducing stress in a nurse with dyslexia or without</u></p>	<p>Grown in confidence</p> <p>Familiarity and routine helped confidence</p>
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**Interview with Lucy – Changes since becoming a registered nurse**

<p><u>Interview 1 with Lucy, p. 1</u></p>		
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<p><b>Lucy:</b> Since you've become a registered Nurse, do you feel as though anything has changed, or anything is different, in relation to your dyslexia?</p> <p><b>Lucy:</b> No.</p> <p><i>BG Not at all?</i></p> <p><b>Lucy:</b> No.</p> <p><i>BG No?</i></p> <p><b>Lucy:</b> It's still the same.</p> <p><i>BG Still the same?</i></p> <p>Yeah.</p>	<p>Very clear and simple answer that's nothing has changed in relation to her dyslexia and being a newly qualified nurse</p>	<p>Nothing's changed</p>
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**Interview with Olivia – Changes since becoming a registered nurse**

<p><b><u>Interview 1, Olivia, p. 1,2</u></b></p> <p><i>BG Since you've become a Registered Nurse...do you feel..., has anything changed, or is anything different, in relation to your dyslexia?</i></p>		
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<p><b>Olivia: well, nothing's changed on that, anything..., nothing on dyslexia-wise, but however, different Trusts...seem to approach it differently...</b></p> <p><b>Olivia:</b> The Trust I'm in now, it's..., the hospital itself is a very smaller hospital, in compared to the one I've just been at... and they just seem to just go, "Yeah, OK" and just sort of carry on with it...they don't seem to..., what's the word? <b>Re-act, well not react, ignore actually, yeah, they don't seem to ignore it, they just accept it all...</b></p> <p><i>BG OK.</i></p> <p><b>Olivia:</b> They would just say, "Yep, OK" and they just carry on. That's the only thing I've noticed MAJORLY so far.</p>	<p>Nothing has changed, however comments on the approach of the Trust to dyslexia</p> <p>Describes the smaller size of the Trust appears to impact upon the approach to dyslexia</p> <p>Comments on how the Trust just appear to accept it, rather than what she has previously experienced</p>	<p>Nothing's changed</p> <p>Different Trust different approach to dyslexia</p>
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## Interview with Marie – Changes since becoming a registered nurse

<p><b><u>Interview 1, Marie, p. 1</u></b></p> <p><i>BG: .....since you've become a Registered Nurse, has anything, you feel, changed, in relation to your dyslexia, as..., as a Registered Nurse?</i></p> <p><b>Marie: It's just more challenging now, because...</b></p> <p>BG Yeah?</p> <p><b>Marie: I mean, there's not the help..., not a lot of help there, that I need, compared to when I was in uni...so, I had to rely more on the computer, and read a bit more.</b></p>	<p>Described since she has become an R.N., it has become more challenging</p> <p>Comments on there is not the help she had at university so reliance on computer and reading more as a result</p>	<p>More challenging</p> <p>Don't have help used to have at university</p>
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## Interview with Chloe – Changes since becoming a registered nurse

<p><b><u>Interview 1, Chloe, p. 1,2</u></b></p>		
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<p><i>BG Since you've become a Registered Nurse, do you feel as if anything has changed, or is anything different, in relation to your dyslexia?</i></p> <p><b>Chloe: Not particularly, I mean, if anything, it's been a bit easier...</b></p> <p>BG Yeah?</p> <p><b>Chloe: Because there's not always someone watching over my shoulder...</b></p> <p>BG Right.</p> <p><b>Chloe:</b> And going, "Oh, what's that, what's that?" kind of questioning me, so, there's no one that reads my notes, asks me...and goes, "Well, that makes no sense, and..." So, if anything, it's a bit easier, because...It's only if anyone ever looks back and goes, "Well, what the hell have you said here?"</p> <p>BG Yeah.</p>	<p>Described that it has become easier, because of not been watched by others</p> <p><i>The term 'not always someone watching over my shoulder' gives an impression of how she felt as a student that she was always been watched and now as a registered nurse, that's now not the case</i></p> <p><i>She further describes this feeling of previously being watched and that no-one now reads her notes. However her description of if anyone looks back and says 'what the hell have you said here; appears to detect she is conscious over others viewing her written work</i></p>	<p>Easier, no-one's watching me</p>
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<p><b>Chloe:</b> That it becomes a problem, so, it makes my life a bit easier.</p> <p>BG OK. Any other reasons it's easier do you think?</p> <p><b>Chloe:</b> I think just don't have to explain myself to everybody...I've got my own paperwork, my work space, and whatever I put on it is..., is my work, and no one else really looks at it, and ultimately, as long as all the dots are plotted in the right places, and...</p> <p>BG Yeah.</p> <p>All the numbers are filled in, and they add up alright, then...No one's really got a problem with it.</p> <p>BG Do you think the nature of the area helps that?</p> <p><b>Chloe:</b> I think so, yeah, I think, because it's like a one-on-one thing...</p> <p>BG Yeah.</p>	<p><i>Develops further this discussion that she doesn't have to explain herself to anyone, that she has her own paperwork, her own workplace – appears to be describing a feeling of independence away from being a student, no indication of anxieties at this point of being a newly qualified nurse</i></p> <p><i>As long as everything is ok, no-one has got a problem with it, appears a feeling of safety and satisfaction in this new role</i></p>	<p>Don't have to explain myself to others anymore</p>
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<p><b>Chloe:</b>.....So, I think because it's one-on-one, I think..., it means I can plan it, and give myself the time I need to do it a bit better.</p>	<p><i>Comments on the one on one nature of intensive care makes a difference</i></p> <p><u><i>Interesting that the nature of a clinical area can impact upon the ease of being a nurse with dyslexia in this case, however would vary tremendously</i></u></p>	
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## APPENDIX 3: Mentors – Data Analysis Tables

### Initial Theme G – Understanding of Dyslexia

#### Interview with Mentor 1A

<p>Interview 1, Mentor 1A, p.1</p> <p>BG How would you describe dyslexia?</p> <p><b>Mentor 1A:</b> Well, I have always <b>thought of it as people getting their words and their letters and things mixed up</b>, like they'll go to write something, and they will actually write the letters that are supposed to be at the back of... and the word at the front, <b>I'm guilty of it myself sometimes.</b></p>	<p>Describing dyslexia as a mixing up of words and writing letters that should be at the back and put them at the front, describes himself as been guilty as that himself sometimes</p> <p><u>This last comment as 'guilty of it myself sometimes' perhaps suggests mixing up of words is something many do which adds to the broadness of the difficulty and blurring of boundaries of this disability</u></p>	<p>Dyslexia mixing up of words</p> <p>Guilty of it myself sometimes</p>
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## Interview with Mentor 2B

<p><b>Interview 1, Mentor 2B, p.1</b></p> <p><b>Mentor 2B:</b> As I understand it, <b>it's an inability, or a difficulty, in recognising letters and numbers, as the majority of the population would recognise.</b></p>	<p>Describes dyslexia as an inability or difficulty in recognising letters and numbers</p> <p><u>Interesting last comment 'as the majority of the population would recognise'. Perhaps stating the majority of the population recognise it as this inability or difficulty suggesting a common understanding</u></p>	<p>Difficulty in recognising letters &amp; numbers</p>
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## Interview with Mentor 3C

<p><b>Interview 1, Mentor 3C, p.1</b></p> <p><b>Mentor 3C:</b> Well, <b>my experience with dyslexia is..., is with people that have difficulty, unscrambling words.</b></p> <p>You know, like set..., a set perception problem, you know, that can be very, very articulate.</p>	<p>Describes difficulty of unscrambling words</p> <p>Describes a set perception problem but can be very articulate</p>	<p>Difficulty unscrambling words</p>
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<p>Read things, have difficulty reading, but also, difficulty in..., in writing, when they have written something, not necessarily seeing that it's not..., it's not the right grammar and spelling.</p>	<p><u>Makes reference to a positive characteristic he sees in dyslexia as being articulate</u></p> <p>Comments further on difficulty reading and writing and not getting the right grammar and spelling</p>	
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### Interview with Mentor 4D

<p><u>Interview 1, Mentor 4D, p.1</u></p> <p><b>Mentor 4D:</b> Oh gosh, <b>dyslexia to me, is somebody who struggles with reading, spelling, writing and that needs extra help.</b> That..., that's how I see it.</p>	<p>Describes dyslexia as struggling with reading, spelling and writing and requiring extra help</p> <p><u>View of needing extra help perhaps perceives dyslexia as an impairment or inability that requires help from others almost placing a medical model angle on dyslexia</u></p> <p><i>Also use of the word 'struggles' is significant in the sense, connecting dyslexia with a struggle, she emphasises dyslexia more as a personal problem or difficulty</i></p>	<p>Struggles with reading, spelling, writing</p> <p>Needs extra help</p>
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## Initial Theme H – Disclosure of Dyslexia

### Interview with Mentor 1A

<p><u>Interview 1, Mentor 1A, p. 12</u></p> <p><i>BG Many nursing students who have dyslexia, are actually often unwilling to disclose their dyslexia to you, can you understand their reasons for not disclosing it?</i></p> <p><b>Mentor 1A: Yeah, I think uhhh...., I mean, anyone..., well, again, relating to my own experiences, I mean, people with a disability, there's always that fear of stigmatisation, and being labelled, if you like.</b></p>	<p>Highlights that relating to his own experiences, admitting previously of his own disability that's there's always fear of stigmatization and being labelled</p> <p><u>Clearly aware from his own experience of both stigma and labelling with regard to disability, argued that someone with or without a disability might be aware of this, but to what degree and in what context</u></p>	<p>Always fear of stigma &amp; labelling</p>
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<p><b>You know, uhhh, you know, people are..., I think people are reluctant to come forward, because they're worried about what people are going to think, and how they're going to react, and what..., how is it going to influence their perception of you, and things like that,</b></p> <p>But..., but I mean, again, you know, I mean with that..., mature student anyway, so, you know, I mean, I can understand it if somebody was very young, like an 18-year old, something like that, it might be a different sort of proportion.</p>	<p>Describes this issue further in terms of reluctance of people with disabilities are worried about what others might think and their reaction and perception</p> <p><u>Again shows an acute awareness of what people with disabilities must feel</u></p> <p>Makes contrast between mature students and a young 18-year old student in terms of the impact or proportion of disclosure</p>	<p>Worried what people are going to think of them</p>
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	<p><u>An insightful contrast that is not really considered in terms of disclosure between ages of student</u></p>	
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**Interview with Mentor 2B**

<p><u>Interview 1, Mentor 2B, p. 15,16</u></p> <p>BG Many nursing students and nurses who have dyslexia, are often unwilling to disclose their dyslexia to others in clinical practice, can you understand their reasons for not disclosing?</p> <p><b>Mentor 2B:</b> No.</p> <p>BG No?</p> <p><b>Mentor 2B:</b> Not at all.</p> <p><b>Mentor 2B:</b> I think..., I personally can, just to quantify that, I..., <b>I can to a degree, where any disability, any..., anything that they may find, that it's going to have them judged.</b></p> <p>May become a problem to disclose it, however, <b>for the nature of the job that</b></p>	<p>Describes initially that she can see to a degree where someone with a disability may be feared of being judged</p>	<p>May be judged by others</p>
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<p>they're coming into...they ..., as far as I'm concerned, their dyslexia should..., should be foremost in..., in...if they are having difficulties within work. And so it's very important, you think, for them to actually tell their Mentors?</p> <p>BG Yes. And if they don't, what..., what's your thoughts there, say if...?</p> <p><b>Mentor 2B:</b> If they don't, and it presents as a problem..., [Pauses], then I don't think I'd have much compassion for them.</p> <p><u>Interview 2, Mentor 2B, p. 35,36</u></p> <p><i>BG Do you think that these people with dyslexia are..., are fearful of being judged?</i></p> <p><b>Mentor 2B:</b> Yeah, I think everybody...I think..., I think yeah, I think we're all fearful of whatever, I don't know why I said no, I think yes, that's probably the case.</p>	<p>However, adds to that by commenting that by the nature of the job of nursing, that dyslexia should be at the forefront of their minds and mentors need to be told</p> <p><u>Appears to suggest that being a nurse with dyslexia is a risk and that mentors should definitely know about it. However, should be consideration of undiagnosed dyslexics and those who simply don't want to disclose for fear of being judged</u></p> <p>Comments if they don't disclose and a problem is presented, she wouldn't have much compassion for them</p> <p><u>Suggests is she prematurely predicting a problem occurring of a nurse with dyslexia?</u></p>	<p>Dyslexia should be foremost in their mind</p> <p>Because of their job, they need to tell their mentor</p>
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<p><i>BG So..., so, having dyslexia, you..., you also have the potential of being judged in a..., in a negative way?</i></p> <p><b>Mentor 2B:</b> Probably, yes.</p> <p><i>BG Yes? Why do you think that is, that's society's view perhaps?</i></p> <p><b>Mentor 2B:</b> Yeah, I think that its ignorance, I think that we don't know.</p> <p><b><u>Interview 2, Mentor 2B, p. 42</u></b></p> <p><b>I hope I don't..., [Pauses], I don't want to come across as being a very judgemental person, but I probably am and that sounds dreadful, just listening to what I'd said to you previously, sounds dreadful, sounds very judgemental, possibly I am.</b></p>	<p>Examines the issue of being judged somewhat further and comments that we're all fearful of something and questions her original 'No' answer</p> <p>Freely admits that having dyslexia does give you have the potential of being judged in a negative way</p> <p>Continues to comment that this is down to ignorance and not simply knowing</p>	
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	<p><u>Looking at comments in interview 1, is she perhaps examining her own fears around dyslexia</u></p> <p>Reflecting on her previous comments about coming across, as she describes, a judgmental person and admits it sounds dreadful and judgmental, but admits possibly she is</p> <p><u>Insightful reflection of her own attitude to dyslexia, revealing in terms of awareness of judgmental issues around dyslexia , but admits possibly I'm judgmental myself, almost an apology for being judgmental</u></p>	<p>I sound very judgmental, probably I am</p>
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**Interview with Mentor 3C**

<p><u>Interview 1 with Mentor 3C, p. 19,20</u></p> <p><i>BG I mean, obviously, Lucy actually did disclose to you about her dyslexia, but some are unwilling to disclose their dyslexia to others in clinical practice</i></p>		
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<p><i>Can you understand some of the reasons for some..., for people who don't wish to disclose?</i></p> <p><b>Absolutely, absolutely. I think..., I think with any..., [Sighs], uhhh, issue around ability, any..., you know, what you can do, as regards written work, it..., generally is seen as reflective of your intellect.</b></p> <p>BG Yeah.</p> <p><b>So, if your written work is poor, you may feel that people may then read that and think that you're ignorant, stupid, lazy, can't be bothered.</b></p> <p>All of those things. I could see..., you know, if I was to put myself in those shoes, I think, you know, <b>as a middle-aged man, I think I could..., I could..., I could deal with that, as a 20 something year old student... I probably wouldn't have, and I also think that I possibly wouldn't have put myself forward to do..., to do an academic course.</b></p> <p>BG Yeah.</p>	<p>Comments that any ability around your written or academic work is seen as a reflection of your intellect</p> <p><u>Makes valued comment around societies connection between literacy and intellect</u></p> <p>Comments further the connection between poor written work, that others may think you're ignorant, stupid, lazy or can't be bothered</p> <p><u>Clearly aware of a stigma around dyslexia</u></p>	<p>Generally dyslexia can be seen reflective of your intellect</p> <p>May be seen by others as stupid, ignorant, lazy</p>
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<p><b>So I'm sure that it holds a lot of people back.</b></p>	<p>Makes comparison that an older person could deal with that, but a younger person wouldn't have risked putting themselves at risk to do an academic course. Which as he states, could put a lot of people back</p> <p>Highlights risks of a younger student with dyslexia putting themselves forward for an academic course</p> <p><u>Does age contribute to disclosure of dyslexia?</u></p>	<p>I'm sure it holds a lot of people back</p>
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**Interview with Mentor 4D**

<p><u>Interview 1, Mentor 4D, p. 19,20</u></p> <p><i>BG: many nursing students who have dyslexia are often unwilling to disclose their dyslexia...to others in practice...can you understand their reasons for non-disclosure?</i></p>		
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<p><b>Mentor 4D: Good God, no, embarrassment I suppose...because they're labelled with something.</b></p> <p><b>Mentor 4D: But no, no, I mean, I think, "Be open with it, don't cover it"</b></p> <p>You know, I think anything, <b>anything, any syndrome you've got, any...abnormality you've got, anything, there's always an embarrassment about it</b>, an element of embarrassment, <b>but the fact that they've actually gone to uni, and decided to be a Nurse, well, "Get over it" [Chuckles], really, there's nothing to be ashamed about, nothing</b></p>	<p>Clearly states that she cannot see any reason for non-disclosure, but comments that embarrassment would be one reason and that they've been labelled with something</p> <p><u>Very definite no to this question about non-disclosure, but understands reasons for this in terms of embarrassment and labelling, so perhaps understands the stigma behind dyslexia</u></p> <p>Comments students should be open about their dyslexia and shouldn't cover it up. Adds that if you got any syndrome or abnormality there will always be an embarrassment about it. However further comments that the fact they've gone to university and made the</p>	<p>Embarrassment – reason for non-disclosure</p> <p>Be open with it, don't cover it up</p> <p>Nothing to be ashamed of</p>
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	<p>decision to become a nurse, there's nothing to be ashamed off and get over it</p> <p><u>Comments denotes a very much 'get on with it' approach to dyslexia, they shouldn't be ashamed about it, however this reveals her own perception about dyslexia as you shouldn't be ashamed about it</u></p> <p><i>Use of terms 'syndrome' and 'abnormality' sees a grappling with what dyslexia actually is and how it might be defined</i></p>	
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## Initial Theme I – Personal Experience of Mentoring a Student Nurse with Dyslexia

### Interview with Mentor 1A

<p><u>Interview 1, Mentor 1A, p. 3,4</u></p> <p>BG: Tell me a bit about your experiences you had with mentoring Emma, was there any sort of concerns from yourselves?</p>		
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<p><b>Mentor 1A:</b> Absolutely not, no. I mean, she is obviously a mature student, you know, somebody with life experiences.</p> <p><b>Mentor 1A:</b> She was self-supportive, if you like, you know, and as I say, she was great, she was a real..., probably one of the best students I've had actually in my own experience, so, you know.</p> <p><i>BG: Now you know that Emma is dyslexic, is this the first time that you have actually mentored a nursing student with dyslexia?</i></p> <p><b>Mentor 1A:</b> As far as I'm aware, yeah, I would never..., in fact, I was just..., I have never had a student say to me, at any time that you know, "I've got a disability"</p> <p><b><u>Interview 1, Mentor 1A, p. 1-3</u></b></p> <p>BG You..., I say you've mentored a nursing student with dyslexia, now, when..., when I rang you and told you that Emma was</p>	<p>Very positive comments about mentoring a nursing student with dyslexia in this instance – 'probably one of the best students I've had'.</p> <p><u>Comments on life experiences and maturity of student, whether that reflects upon the outcome of the student, difficult to determine</u></p> <p>Comments that he has never had a student who stated I've got a disability</p>	<p>Self-supportive, best student I've had</p>
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<p>dyslexic, you weren't aware of that at the time?</p> <p><b>Mentor 1A:</b> No.</p> <p>BG: Is that correct?</p> <p><b>Mentor 1A:</b> That's right, yeah, yeah.</p> <p>BG What was your reaction when I told you that, when I said..., when I revealed..., was that a surprise to you?</p> <p><b>Mentor 1A:</b> Well, it doesn't bother...I mean, it..., it clearly hadn't been an issue in her work.</p> <p>BG Sure.</p> <p><b>Mentor 1A:</b> you know, I mean, it's a <b>medical condition like any other, to be fair, and..., and what you look at is the ability of the person to do the job.</b></p>	<p>Comments that dyslexia hasn't been an issue in her work.</p> <p><u>However because he was not aware she was dyslexia, does a lack of awareness result in a mentor simply not looking for or expecting a difficulty</u></p> <p>Describes dyslexia as a medical condition and also describes how</p>	<p>Weren't aware she was dyslexic until you told me</p>
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<p><b>Mentor 1A:</b> I mean, I am partially deaf and I am partially sighted, so, I mean, clearly I am able to do this job.</p>	<p>you look at the ability of someone to do the job, rather than the impact of their disability</p>	
<p>BG Sure.</p>	<p><u>Views dyslexia perhaps from the medical model of disability which adds to the differing interpretation of what dyslexia is.</u></p>	
<p><b>Mentor 1A:</b> So why someone with dyslexia should have an issue.</p>	<p><u>In his description of how you look at the ability of someone to do the job rather than their</u></p>	
<p>You know, I have always been open-minded about that kind of thing anyway, probably because of my own experiences.</p>	<p><u>disability, he perceives disability as not something that should be pre-judged, rather can the person do the job</u></p>	
<p>BG Sure.</p>	<p>Goes onto describe his own disability and reiterates he can do the job despite his disability</p>	<p>It's a medical condition</p>
<p><b>Mentor 1A:</b> My own perceptions, you know. <b>But what I look for, particularly with students, is, you know, "Do you have the ability to do the job?"</b></p>	<p>Comments why should someone with dyslexia have an issue and described his open mindedness about such issues because of his own personal experiences</p>	<p>Look at the person's ability to do the job</p>
<p>BG Yeah.</p>		

<p><b>Mentor 1A: You know, with or without a disability. And I'm..., I'm certainly not prejudiced towards any kind of disability.</b></p> <p>Or anything like that.</p>	<p><u>His own experience with his own disability has clearly influenced his own perception and approach to disability with others, namely students.</u></p> <p>Again re-iterates his own perceptions of has the student got the ability to do the job with or without a disability</p>	<p>Why should someone with dyslexia have an issue?</p> <p>Not prejudiced to any kind of disability</p>
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**Interview with Mentor 2B**

<p><u>Interview 1, Mentor 2B, p. 2,3</u></p> <p>BG Now, as you said at the beginning, you mentioned a nursing student with dyslexia. Can you tell me something about those experiences?</p>		
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<p><b>Mentor 2B:</b> I didn't realise that Holly was, had dyslexia until she presented me with..., I'm quite vigorous with the students, and I set her written work, as well as practical skills, and we go over a lot of the clinical side on paper.</p> <p><b>Mentor 2B:</b> And she presented me with a piece of paper..., [Chuckles], and I've been <b>advised not to tell you what I said to her, but it was something to the effect of [Chuckles], "Are you stupid, or have you got dyslexia?" Not thinking that she would say... "Actually, I've got dyslexia"</b></p> <p><b>Mentor 2B:</b> And then she said, "Why do you ask?" [Continues to Chuckle], and I said, "Well, because this is a pile of rubbish that you've presented me with, it doesn't make any sense"</p>	<p>Describes her reaction to receiving a piece of written work from Holly and stating 'are you dyslexic or stupid? And her response was actually I've got dyslexia</p> <p><u>Very revealing description of this incident in terms of putting the two words of 'dyslexia' and 'stupid' together and asking which one are you? Making comparisons between dyslexia and being stupid reveals she is almost connecting these two closely linking dyslexia to having serious problems with literacy</u></p>	<p>Are you stupid or have you got dyslexia?</p>
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<p><b>Mentor 2B:</b> And so then she said usually, she does her work on her computer with the Spellcheck. And so, because I had set her this piece of work, she had just scribbled it out, and so there were going to be spelling mistakes on it.</p> <p>So, that's how I discovered that she had dyslexia</p> <p>BG: And how did you react when she said "Yes, I do have dyslexia"?</p> <p><b>Mentor 2B:</b> Well initially, I was apologetic. Because I..., as I said to you on the phone, I my mouth engages before my brain, [Chuckles]. So ..., [Chuckles], <b>so, I was a bit embarrassed that I had suggested that she was stupid [Continues to Chuckle], but although, as I said, that wasn't the..., that wasn't the terminology that I had used for ..., and <u>then I was surprised that she was pursuing nursing</u></b></p>	<p><u>Describes further this incident responding to the students answer, 'this is a pile of rubbish.... it doesn't make any sense'</u></p> <p>Describes that the student usually does her work on a computer using spell check, but instead on this occasion had written it out</p> <p><u>From this perspective, this might be described as a rather unfair unplanned assessment on someone who has difficulty writing at short notice and thus difficulties were more exposed and more apparent</u></p>	
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<p><b><u>Interview 1, Mentor 2B, p. 4-7</u></b></p> <p><i>BG So, what were your initial thoughts when Holly told you she was a dyslexia..., dyslexic, what sort of thoughts were going through your mind?</i></p> <p><b>Mentor 2B: Well, my very first thought was, “She’s in the wrong job”</b></p> <p><i>BG: Why did you think that?</i></p> <p><b>Mentor 2B: I think because a lot of our clinical works are now transcribed into paperwork. And..., and computer. And there’s so much more paperwork, expected from us, but, any..., well it’s bad enough trying to spell correctly words</b></p>	<p>Describes her reaction when realising she was dyslexic, being apologetic and embarrassed, however claims the word ‘stupid; wasn’t the word she used. However comments she was surprised she was pursuing nursing</p> <p><u>Understandable reaction of being apologetic and embarrassed when she realised she was dyslexic, however of particular impact was her surprise she was pursuing nursing suggesting you can’t pursue nursing if you have dyslexia. Clearly appears to be linking an individual with dyslexia with their ability to become an nurse</u></p>	<p>Surprised that she was pursuing nursing</p>
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<p>that you're..., that you're given to..., to spell, procedures. Calculations of drugs that sort of thing.</p> <p><b>Mentor 2B:</b> And I just thought, "This isn't going to work for this girl, which is a shame, because practically, she's a really good nurse"</p> <p>And it hadn't come to fruition until I had from that point.</p> <p><i>BG: Going back to that point I said we'd come back to, what's your own particular thoughts, perceptions, preconceived ideas that you said, about a nurse with dyslexia in practice?</i></p> <p><b>Mentor 2B:</b> I wouldn't want her looking after me.</p> <p>BG: OK. Why is that?</p>	<p>Comments that she thinks she's in the wrong job being in nursing</p> <p><u>A rather surprising statement, appears to indicate she thinks you can't be a nurse if you're dyslexic</u></p> <p>Gives justification for this answer by describing the amount of paperwork and use of computers as well as calculations nurses now have to do</p> <p><u>Appears to have a very well embedded perception that a nurse with dyslexia would have great difficulty performing such tasks</u></p>	<p>First thought, she's in the wrong job</p> <p>A shame, because practically, she's a really good nurse</p>
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<p><b>Mentor 2B:</b> Mostly because I have also mentored nurses, who were stupid, [Chuckles], and got diagnosis mispronounced, things like..., just a simple thing. I was trying to think of something before I spoke to you, about what my example might be something like <i>dysphasia</i> or <i>dysphagia</i>.</p> <p><b>Mentor 2B:</b> I haven't looked into dyslexia at all, I know a few celebrities have said that...stated that they've got dyslexia. But it's not something that I have considered.</p> <p><b>Mentor 2B:</b> Not something that I..., because I don't have anybody close that has dyslexia, it wasn't something that I had come across, presented itself in any sort of problematic way.</p> <p><b>Mentor 2B:</b> And I felt that the student ..., [Pauses], coming into nursing with it, could be a problem, not just for her, but for the patients that she is going to be looking after.</p>	<p>Then comments that this isn't going to work for her, which is shame as practically she's a really good nurse</p> <p><u>Separates out her attributes as a good practical nurse, but in stating this isn't going work for her is considering more her academic ability to write, rather her difficulties in literacy and places greater emphasis upon this than anything else</u></p> <p>Very clear statement that she wouldn't want her looking after her as a patient</p> <p><u>Considers herself as a patient and a nurse with dyslexia looking after her expressing her fears around this. Reveals her real fears</u></p>	
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<p><i>Q. What kind of things might..., were you fearful that might occur with a patient?</i></p> <p><b>Mentor 2B: Mostly, the spelling of..., of conditions and calculations. I thought <u>if she had got a problem with numbers, that could be..., [Pauses], potentially dangerous.</u></b></p> <p><b><u>Interview 2, Mentor 2B, p. 3,4</u></b></p> <p>BG: You said that you were surprised that she was pursuing nursing when..., when she told you she had dyslexia?</p> <p>Why..., why was that? What were your first thoughts then, when...?</p> <p><b>Mentor 2B:</b> I think because..., [Pauses], there's a great..., there's a greater emphasis on the academic side...of nursing now.</p>	<p><u>and concerns about a nurse with dyslexia</u></p> <p>Discusses further this issue and describes she has mentored nurses who were stupid and got diagnosis terminology mispronounced such as dysphasia and dysphagia which are speech difficulties associated with strokes</p> <p><u>Giving an example of confusion over similar sounding words such as dysphasia and dysphagia, but then many people could get these words confused, don't have to be dyslexic to have this confusion, there is only one letter difference between these words g and s</u></p> <p>Admits have not looked into dyslexia, but aware of some celebrities who have it</p>	
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<p><b>Mentor 2B: And so therefore, she would have a....., while her clinical skills were second to none, her academic side MAY hold her up, or present problems for her, which will be..., which will be difficult.</b></p> <p><b><u>Interview 2, Mentor 2B, p. 7,8</u></b></p> <p><i>BG: Would you think differently with that, with Holly now? Do you think that she's still..., you know, in the right job, or was that just a reaction?</i></p> <p><b>Mentor 2B: Well I don't... You see, it's difficult, because I still would feel that if she was..., if she was a nurse looking after me...I would still be questioning whether she had got the dosage right of..., of prescriptions that she's giving to me.</b></p>	<p>Also states that she has none in her family that has dyslexia therefore has no real experience of it</p> <p>Again re-iterates that a student coming into nursing could be a problem not just for her, but the patients she's looking after</p> <p>Gives further detail when asked what might occur with a patient looked after by a nurse with dyslexia and states of a potential danger</p>	<p>Problem for her, but patient's she's looking after</p> <p>Could be potentially dangerous</p>
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<p><b>Mentor 2B: Or whether she had written down my diagnosis right, I would still be..., [Pauses], cautious about her written, uhhh..., uhhh, and numeric work.</b></p> <p><b>Clinically, her nursing care, no, I would have her looking after me tomorrow.</b></p> <p>BG So..., so, the nursing care would be fine?</p> <p><b>Mentor 2B: Her nursing care was fine. it was PURELY that the academic side of it.....</b></p>	<p><u>Her statements clearly show a very definite belief of the potential dangers of a nurse with dyslexia, perhaps demonstrating a almost lesser understanding about dyslexia</u></p> <p>Response to further questions on these issues she comments that there's a greater emphasis on the academic side of nursing now, than previously</p> <p>Comments her clinical skills were second to none, but her academic side may hold her up or present problems for her</p>	
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	<p><u>Appears to separate out practical clinical skill and academic side of nursing highlighting it is the academic side of nursing she would experience difficulties with. Clearly identifying dyslexia with academic difficulties</u></p> <p>Still expresses her fears of Holly looking after her in terms of confusion over drug dosages and prescriptions, written and numeric work etc.</p> <p>However now states her nursing care is such, 'would have her looking after me tomorrow</p> <p>Comments that her nursing care was fine, it was purely the academic side</p>	<p>Would question whether she has got dosage right</p>
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	<p><u>Therefore, her concern appears to be purely the academic ability as a direct connection to her dyslexia. Separates out her practical skills and academic ability and it is this which is her greatest concern</u></p>	
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## APPENDIX 4: Tutors – Data Analysis Tables

### Initial Theme M – Knowledge & Understanding of Dyslexia

#### Interview with Tutor 1A

<p><u>Interview 1, Tutor 1A, p. 2</u></p> <p><b>Tutor 1A:</b> .....from my experience, it seems to affect people differently. Some people have severe dyslexia.</p> <p><b>Tutor 1A:</b> And it really gets in the way of them achieving.</p>	<p>Comments that it does affect people differently and some may have severe dyslexia</p> <p><u>Recognises the variability of dyslexia in terms of affecting people differently and also a knowledge of severe dyslexia</u></p> <p>Identifies how dyslexia can get in the way of achieving</p>	<p>Affects people differently</p>
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<p><b>Tutor 1A:</b> Their..., in their academic work, and in practice, and some students seem to have adapted, or it's not so bad.</p> <p><b>Tutor 1A:</b> And they can manage. So, I think what I've seen is that lots of students have dyslexia, but it seems to vary in severity from quite mild to quite severe.</p> <p><b>Interview 2, Tutor 1A, p. 4, 5</b></p> <p><b>Tutor 1A:</b> .....I've recently seen somebody's assessment, where it talks about intellectual level. And memory, and so when you see that report...That</p>	<p><u>This comment clearly states that dyslexia 'really gets in the way of achieving' pointing towards the negatives and disadvantages of being dyslexia within academia</u></p> <p>Further comments that in both academic work and practice, some have seemed to have adapted or it's not so bad</p> <p><u>This adds to earlier comment that some adapt, or it's not too bad, further extending her knowledge to the variability of dyslexia</u></p> <p>Reiterating her understanding of dyslexia on commenting on the variability of dyslexia from mild to severe</p>	<p>Can get in the way of them achieving</p> <p>Vary in severity from mild to quiet severe</p>
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<p>gives you more of an idea of how severe...or not severe something would be,</p> <p>.....but usually you've not seen that, and so you go on what the student says, if the student says, "Oh, I'm really bad" we think, "Crikey, they must be really bad if they're telling you they're bad" but others will say that it's..., you know, that it doesn't affect them too much. And that they can manage their difficulties. <b>So basically, you go by what the student says, which is VERY approximate, isn't it?</b></p> <p><b>Tutor 1A:</b> If you've read their report, their assessment, then you're..., <b>you're not in the dark, then you've got a little bit more insight.....I think it gives you a little bit more basis for what you might expect from your student, or what they might need, but I think that a lot of the time we're working in the dark</b></p>	<p>Adds further to previous comments about the contents of an assessment which provides details of intellectual level which gives you more information about the severity of dyslexia</p> <p>However adds on most occasions, she hasn't actually seen that assessment and have to go on what the student tells them</p> <p>Comments if the student says I'm really bad, states, 'they must be really bad if they're telling you they're bad'</p> <p><u>Interesting observation that if the student says they're bad, they must be bad. Very much influenced by what the student tells them about their dyslexia</u></p>	<p>Rarely see the dyslexia assessment</p> <p>Go by what the student tells me about their dyslexia</p>
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<p><b>Tutor 1A: We don't have much evidence for what helps these students. We don't have much understanding of what's severe, what's not severe, how it presents. And so I think, you know, as a Course Director and academic, you..., you're led by the student really.</b></p> <p>And you just hope that they manage. You hope that they keep passing</p>	<p>Reiterates this further going by the student tells you about their dyslexia makes it very approximate</p> <p>Access to the report gives a clearer insight of what to expect from the student or what they might need, but comments a lot of the time we're working in the dark</p> <p><u>Interesting comments from a tutor's perspective of 'a lot of the time we're working in the dark' perhaps demonstrating lesser knowledge of what they're dealing with</u></p> <p>Describes how as tutors they don't have much evidence what helps the students and much understanding of what's severe and what's not severe and again are led by the student</p> <p><u>Reiterates the key issue that the tutors have little information about the student's dyslexia, and are mainly reliant from what the student tells them</u></p>	<p>Not much understanding of what's severe and</p>
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	<p><u>Final comment that they hope that they manage and hope they keep passing suggests in the is case a tutor has little control on how they might support a student with dyslexia</u></p>	<p>what's not severe</p>
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**Interview with Tutor 2B**

<p><u>Interview 1, Tutor 2B, p.1</u></p> <p><b>Tutor 2B:</b> I would describe it as someone who has, perhaps, difficulty in some aspects of reading or writing. My own personal experiences have led me to realise that there is more than one form of dyslexia. But if I was supposed to just categorise it, I suppose I would say yes, difficulty in perhaps reading and writing.</p>	<p>Describes as difficulty in aspects pf reading and writing and cites personal experience has led her to realise there is more than one form of dyslexia</p> <p><u>A basic understanding however personal experience has provided additional understanding which demonstrates how contact with an individual who is dyslexic can increase both knowledge and understanding</u></p>	<p>Difficulty in some aspects of reading and writing</p> <p>More than one form of dyslexia</p>
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## Interview with Tutor 3C

<p><u>Interview 1, Tutor 3C, p. 1,2</u></p> <p><b>Tutor 3C: How would I describe dyslexia? Probably, that it takes many forms.</b></p> <p>And there's different..., many types of it. I think that <b>my understanding is that it presents difficulties for individuals and students.</b></p> <p><b>Tutor 3C:</b> In how they write and form sentences. In terms of difficulties around grammatical structure. Understanding words, and then it also translates the difficulties in terms of how they are able to receive and process information, which is different to, you say...what one might refer a..., a student without dyslexia.</p> <p><u>Interview 2, Tutor 3C, p.1</u></p>	<p>Quite a detailed understanding of dyslexia describing it as taking many forms, difficulties with grammatical structure and receiving and processing information and differentiating these characteristics against a student without dyslexia</p> <p><u>Differentiating against a non-dyslexic student making clear differences that a dyslexic student might present with in contrast to someone without dyslexia</u></p>	<p>Dyslexia takes many forms</p> <p>Affects their ability to receive and process information</p>
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<p><b>Tutor 3C:</b> I'm aware of different ways that people, confuse letters and sentences.....may need different shades of colouring...in order to understand written words,</p> <p>I think also, in terms of the presentation of information to people with dyslexia, so, PowerPoints don't always work for instance.....and you need to sort of try and make the sort of adjustments for those kinds of things</p>	<p>Further detail of how someone with dyslexia may confuse letters and sentences, may need different shades of colouring etc.</p> <p>Discussion of presentations such as power points don't always work and a need to make adjustments</p> <p><u>Clearly aware of difficulties a student with dyslexia will face as well as adjustments that might be required</u></p>	<p>May need different colour shades to understand written word</p>
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### Interview with Tutor 4D

<p><u>Interview 1, Tutor 4D, p. 1</u></p> <p><b>Tutor 4D:</b> My understanding, of dyslexia, is that it's usually it's where the person, or people, have difficulty with learning, it could be with, you know, either writing</p>	<p>Descriptive understanding of dyslexia describing it as difficulty with learning,</p>	<p>Difficulty with learning –</p>
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<p>or reading skills, working out problems like maths and things like that, it's actually how..., that's what the impact of..., of dyslexia is.</p> <p><b><u>Interview 2, Tutor 4D, p.1,2</u></b></p> <p><i>BG: What kind of difficulties do..., difficulties do you think they would have with writing or reading?</i></p> <p><b>Tutor 4D:</b> From..., I mean, from what I know, is, I don't know, I wouldn't say I'm..., I'm a 100% on...on that, but, from what I remember, it's usually following lines...when they're reading, can't follow...the..., the appropriate lines.</p>	<p>writing or reading skills, working out problems such as maths</p> <p>Adds further detail to her understanding that what she remembers, it is difficulty usually following lines when reading</p>	<p>writing and reading skills</p> <p>Difficulty following lines when reading</p>
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**Interview with Tutor 5E**

<p><b><u>Interview 1, Tutor 5E, p. 1</u></b></p> <p><b>Tutor 5E:</b> A limited amount I would say, and it's mainly through contact with students, who <b>I rely on, to an extent, to tell me what their specific needs are.</b></p> <p><b>So, I know that quite a few people who have dyslexia, have difficulty reading the written word, and that can be a number of different forms, so, their..., they can find their words being disordered, the letters being jumbled, and so, understanding the written word is problematic....</b></p> <p>And some people find there are different ways that that can be helped. So, some students for example, prefer black writing on yellow paper and they cope better if you give them the material in advance, and they can look through it in advance, and there are other students who do better with, technology, assistive technology, where the..., their</p>	<p>Admits a limited amount from the beginning, but states that she relies upon students to tell her what their specific needs are</p> <p>Comments on that people with dyslexia have difficulty reading the written word, find words being disordered or jumbled as well as understanding the written word can be problematic. Also comments on a number of different forms of dyslexia</p> <p><u>Interesting comments that she relies upon students to tell her what their specific needs are rather than using any previous knowledge or experience about dyslexia, perhaps this approach adds to the individuality and specific needs of a student with dyslexia rather than reliance upon a standard approach</u></p> <p>Describes different ways a student with dyslexia can be helped in terms of coloured paper, some better with</p>	<p>Rely on students to tell me their specific needs</p> <p>Takes different forms</p> <p>Words disordered and jumbled up</p>
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<p>technology can read them PowerPoint slides or hand-outs or books. but then there are variants.</p> <p>And some students have specific needs, and so you really have to find out from each student, what their preference is.</p>	<p>assistive technology, however comments there are variants.</p> <p><u>Description identifies some previous knowledge and experience of helping dyslexic students, which it is assumed will strengthen her support of dyslexic students</u></p> <p>Again reiterates the importance of finding out from each student what their particular preference is</p>	
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### Interview with Tutor 6F

<p><u>Interview 1, Tutor 6F, p. 1,2</u></p> <p>BG: what do you know about dyslexia, how would you describe it?</p> <p><b>Tutor 6F:</b> My understanding, of dyslexia, is that it's a developmental condition that results in a mixed, or unusual</p>	<p>Quite a detailed and accurate description of dyslexia, particularly a 'mixed or unusual balance of skills relating to information processing'</p>	<p>Developmental condition with mixed or</p>
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<p>balance of skills relating to information processing.</p> <p>BG</p> <p>Yeah.</p> <p><b>Tutor 6F:</b> That can be, information processing, relating to cognitive aspects, such as, the reception of messages. The perception of messages, the interpretation, storage, and I suppose, ultimately, retrieval of messages, and the sequencing of that.</p> <p>BG Yeah.</p> <p><b>Tutor 6F:</b> And also, I suppose, a second element is speed of processing. It can affect...and...all of those, elements, are very individualised.</p> <p><b>Tutor 6F:</b></p> <p>Dyslexia, is a sort of variable, it's referred to as a specific learning difficulty these days, isn't it? rather than a..., than a..., than a disability. So, my experience is that you can have people who are fairly</p>	<p>shows quite an advanced knowledge of dyslexia from this tutor.</p> <p>Again provides more detail to her response mentioning reception, perception, interpretation and storage of messages</p> <p><u>Interesting to note she hasn't used the word difficult at any point so far, rather his description is an observation of characteristics or elements rather than difficulties</u></p> <p>Comments how very individualised the elements of dyslexia can be showing her recognition of differences between one dyslexia and another</p>	<p>unusual balance of skills</p>
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<p>mild dyslexia, moderate, or even quite severe dyslexia, in terms of the balance of skills and impact, but people can still be quite high functioning, in terms of ac..., aca..., academic...</p>	<p>Describes further this variability, but also mentions that it's referral today as a specific learning difficulty rather than a disability. Adds to this variability by highlighting the mild, moderate and severe types of dyslexia</p> <p>Comments on the balance of skills and impact, but highlights high functioning in terms of academic work</p> <p><u>Recognition of high functioning in dyslexics referring to the high intelligence of many connects dyslexia in her perception as intelligent</u></p>	<p>Mild, moderate or severe</p>
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## Initial Theme N – Experiences with a Dyslexic Nursing Student

### Interview with Tutor 1A

<p><u>Interview 1, Tutor 1A, p. 7-10</u></p>		
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<p>BG: Could you tell me about your own experiences with that student, whether that be positive or negative?</p> <p><b>Tutor 1A:</b> It was positive, it..., <b>it was a bit tricky, positive but a bit tricky, because one of my students couldn't see how her dyslexia was affecting her written work.</b></p> <p><b>Tutor 1A:</b> Although she knew she was dyslexic, she couldn't quite see how it was affecting her marks.</p> <p>BG OK</p> <p><b>Tutor 1A:</b> So, it was a bit tricky to sort of explain, "This is why it's not..., this written piece of work hasn't done so well with the marks"</p>	<p>Comments on a positive experience, but one that was tricky because the student couldn't see how her dyslexia was affecting her written work</p> <p><i>Use of term 'tricky' suggests not difficult but perhaps caused me some problems or perhaps made me think</i></p> <p>Describes despite the student knew she was dyslexic, she couldn't see how it was affecting her marks</p> <p><u>Shows a differing perception of the dyslexic student who couldn't see the impact of her dyslexic on her written work and thus her academic marks. How might a dyslexic student perceive her difficulty?</u></p> <p>Goes on further to describe and explain the 'trickiness' of explaining to the student why she had done so</p>	<p>Bit tricky, student couldn't see how it was affecting her work</p>
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<p><b>Tutor 1A:</b> and to do that sensitively, and not to affect anybody's confidence.</p> <p>BG No.</p> <p><b>Tutor 1A:</b> But not bad, So, my experiences? Well obviously, the student I know who had to leave, I felt quite sad for.</p> <p>BG: Tell me a bit more about that.</p> <p><b>Tutor 1A:</b> Well, she came across brilliantly, a hardworking, motivated, but I know she got all the support that was ...available, but it's just a shame, you know, but I guess that at the end of the day, people have to pass the assessment criteria, the criteria is what it is.</p>	<p>not so well in her marks, but at the same time do it sensitively so not to affect the students confidence</p> <p><u>On the tutor's part, shows an awareness of sensitivity towards the dyslexic student of the impact of her critical feedback on her work.</u></p> <p><u>Perhaps a feeling of enhanced awareness of the psychological impact of dyslexia</u></p> <p>Describes the experiences of a dyslexic student who had to leave because the difficulties faced by her dyslexia and how sad she felt about that experience</p> <p>Comments on how hardworking and motivated she was and got all the support that was available, but further comments what it comes down to is having to pass the assessment criteria</p>	
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<p><b>Tutor 1A:</b> .....but yeah, that was a bit disappointing, I felt a bit sorry for her, well, very sorry for her really.</p> <p><b>Tutor 1A: Other students, a bit of a battle, somebody I'm working with one at the minute, who has got dyslexia, it is going to be quite hard work to support his academic development.</b></p> <p>BG: Ok</p> <p><b>Tutor 1A:</b> Absolutely confident with intelligence, the ideas and the knowledge, but I can't write the work for him, so, he is going to have to do that, and that is going to be quite hard I think, you know, and so it's gonna be..., I think it's gonna be a bit challenging from my point of view.</p> <p>BG</p>	<p><u>Contrasts between the hardworking motivated individual this student was, however emphasises the importance and significance of the passing of the assessment criteria. Difficult to co-relate without further details of this case</u></p> <p>Expresses her disappointment over this nurse leaving as a result of her difficulties associated with her dyslexia</p> <p><u>Shows her understanding and disappointment of this particular student, almost a feeling of sympathy of her difficulty</u></p> <p>Describes 'a bit of a battle' with one student with dyslexia going on further to describe it as quite hard work to support him</p> <p><i>The word 'battle' suggests a feeling of a struggle in supporting this student</i></p>	<p>'bit of a battle'</p>
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<p>Mmm hmm.</p> <p><b>Tutor 1A:</b> Because I can't do it for him, he has to do it.</p> <p>BG: Sure.</p> <p><b>Tutor 1A:</b> .....but interesting as well to try and find some ways to... Actually, I've got another..., I've got another student whose dyslexic.</p> <p>BG: OK.</p> <p><b>Tutor 1A:</b> Who is also a Masters student, doing a dissertation, and no, really hardworking, very able, but yeah, the writing side, [<i>Chuckles</i>], it's a bit of a..., takes a bit of extra support.</p> <p>BG: What kind of particular problems do they have in writing?</p> <p><b>Tutor 1A:</b> Probably..., <b>it's probably the same issues that lots of people have, to be honest.</b></p> <p>BG: Yeah.</p>	<p><u>Clearly this is described in a way that is a difficult task that will take both time and energy</u></p> <p>Comments on the confidence, intelligence and ideas of this individual, but in contrast to this positive description states she can't write the work for him and describes it as challenging from her point of view</p> <p><u>Her description has two contrasts of positive in terms of the favourable characteristics of the student but also it's going to be quite hard and challenging for her point of view.</u></p> <p><u>From these comments, is support for a dyslexic student just hard work?</u></p>	
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<p><b>Tutor 1A: It's only that I know that they have got dyslexia, because they have said, but...lots of students struggle with getting ideas in the right order.</b> With flow, getting the paragraphs to flow. Sometimes to get the depth, without getting it all muddled up.</p> <p><b><u>Interview 1, Tutor 1A, p.11</u></b></p> <p>BG: Is there any way to actually differentiate between the students without dyslexia and the ones with, in terms of the difficulties that they have, or are they similar?</p>	<p>Gives another example of another student who is a Masters student doing a dissertation commenting on how able he is, but then comments of the difficulties with the writing side and will take a bit of extra support</p> <p>Now comments in answer to the question on writing, that lots of people have the same issues</p> <p><u>This is a significant observation that others who don't have dyslexia have the same issues as those she described with dyslexia</u></p>	<p>Same issues a lot of people have</p>
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<p><b>Tutor 1A:</b> No</p> <p>BG: Or are they any worse, or...?</p> <p><b>Tutor 1A:</b> I think it's really hard, <b>because we take students with a diverse..., diverse backgrounds diverse qualifications, so, some students really struggle academically anyway. It's not because they're dyslexic.</b></p> <p><b>Tutor 1A:</b> It's because they have not had enough practice, or they,.... you know, they have not learned some of these essential skills, you know, go with writing and reading if they're not dyslexic, but they just need to develop further, and that could take years. I mean, people are always learning and developing, and just because people have got to university, it doesn't mean they are where they are going to be for the rest of their lives, and I think that's really important to remember, [Chuckles], so, I don't know, sometimes it doesn't matter if you know or not.</p>	<p>Further comments that I know they have dyslexia, because they have said, but then describes how lots of students struggle with getting ideas in the right place</p> <p><u>This is quite revealing in terms of she only knows they have dyslexia because they've told her, but many students have similar difficulties.</u></p> <p><u>This questions whether other students may have had dyslexia, but didn't tell her or were unaware they had dyslexia or many students have similar academic difficulties, but are not dyslexia. Provides a far more broader thought on difficulties with literacy, are the boundaries between dyslexics and non-dyslexics far more blurred than first thought?</u></p> <p>In answer to a question whether it's possible to differentiate between students with and without dyslexia, a clear No to that question, but further comments that they take students with diverse backgrounds and qualifications who really</p>	
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	<p>struggle academically and it's not because they're dyslexic</p> <p>Adds further to these comments by stating it's because they've not learnt some of these essential skills with writing and reading and might be dyslexic, but might just need to develop further</p> <p><u>Quite revealing as it clearly sets out a very diverse student population in her view who come from different educational backgrounds and who could take years to develop</u></p> <p>Final comment that it doesn't really matter if she knows or not that the student has dyslexia</p> <p><u>This sums up many of her comments in one short sentence really that it doesn't matter if you know or not,</u></p>	<p>Some students struggle academically, it's not because they're dyslexic</p>
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	<p><u>the difficulties may be similar or the same across both dyslexics and non-dyslexic students</u></p>	
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## APPENDIX 5: Preceptors – Data Analysis Tables

### Initial Theme P – Knowledge and Understanding of Dyslexia

#### Interview with Preceptor 1A

<p><u>Interview 1, Preceptor 1A, p.1</u></p> <p><i>BG Tell me, to start off with, what do you know about dyslexia?</i></p> <p><b>Preceptor 1A:</b> Not a lot really, I just know it..., it..., it's something that makes people find reading and writing difficult, and..., and the effects it can affect sight, in the way people write things down...and things like that.</p>	<p>Admits a limited understanding from the beginning, but describes dyslexia that makes people find reading and writing difficult and can also affect sight and the way people write things</p> <p><u>Clearly quite a limited understanding of dyslexia, but focuses particularly on the literacy difficulties associated with dyslexia specifically reading and writing</u></p>	<p>Dyslexics find reading and writing difficult</p>
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## Interview with Preceptor 2B

<p><b><u>Interview 1, Preceptor 2B, p. 1,2</u></b></p> <p>BG: What I'm going to start off with, what do you know about dyslexia?</p> <p><b>Preceptor 2B:</b> Well, it..., it..., it's how you write things down... from what I..., I remember when I was at school, my friend had dyslexia, and she did like her D's and her B's back to front...and sometimes, it's..., it's sort of how to, I think, like how you express yourself...</p> <p>BG Oh yeah, OK.</p> <p><b>Preceptor 2B:</b> But a lot of it is in how you write things down...spelling, I think is...is one of the main things that sort of jumps to mind.</p> <p>BG Sure.</p>	<p>Refers to school experience of a friend at school who had dyslexia putting her B's and D's back to front and also refers to how you express yourself</p> <p><u>Often previous experiences of knowing others with dyslexia somewhat shapes your own understanding of it, therefore this recalling of her experience of her friend at school with dyslexia has increased her understanding</u></p> <p><u>Comments on the literacy difficulties associated with dyslexia such as spelling which are more familiar to the general population about what dyslexia is</u></p>	<p>Getting Ds and Bs back to front</p> <p>How you write things down, spelling!</p>
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<p><b>Preceptor 2B:</b> I think people with dyslexia sometimes, often, are..., are very worried that..., that they can't write things...they can do the things...but they can't always write the things down...so people can like, read it.</p>	<p>Comments on how people with dyslexia can be worried that they can't write things down</p> <p><u>Refers to the personal side of dyslexia with regard to worry from someone with dyslexia if they can't write things, Perhaps attempting to see it from the perspective of the person with dyslexia</u></p>	
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### Interview with Preceptor 3C

<p><u>Interview 1, Preceptor 3C, p.1</u></p> <p><i>BG To start off with, what do you know about dyslexia?</i></p> <p><b>Preceptor 4D:</b> Well, just..., [Chuckles].I don't know much, but it's just people who can't..., I don't know, I..., they can't spell? I don't know...I don't know MUCH about dyslexia.</p> <p><u>Interview 2, Preceptor 3C, p.1</u></p>	<p>Admits she doesn't know much about dyslexia but describes dyslexia as people who can't spell</p> <p><u>Identifies dyslexia directly as a literacy difficulty in terms of a</u></p>	<p>They can't spell</p> <p>Don't know much about dyslexia</p>
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<p><i>BG Have..., since I spoke to you, have you sort of picked up anything further about dyslexia, or just...?</i></p> <p><b>Preceptor 3C:</b> No.</p> <p><i>BG No? Is spelling one of those things that you identified with dyslexia?</i></p> <p><b>Preceptor 3C:</b> Well, with..., no, it's because when you ask people...what..., what are they struggling with, with some of them... they..., they can't remember how to spell.</p> <p><i>BG Ok, spelling is one of the things that you notice?</i></p> <p><b>Preceptor 3C:</b> Yeah, and they can't do things as quick as...others, you know, that's it.</p>	<p><u>spelling difficulty and generalises somewhat stating 'they can't spell'</u></p> <p>Further questioning about the understanding of dyslexia, she provides further details about those with dyslexia can't remember to spell</p> <p><i>Interesting use of the word 'struggling' when she asks what they are struggling with. Is she perceiving dyslexia as a struggle?</i></p>	<p>Can't do things as quick as...others</p>
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	Comments that those with dyslexia can't do things as quick as others	
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### Interview with Preceptor 5E

<p><b><u>Interview 1, Preceptor 5E, p. 1,2</u></b></p> <p><i>BG: To start off with, what do you know about dyslexia?</i></p> <p><b>Preceptor 5E:</b> I know that it's people with dyslexia, actually see written forms in...in a different way</p> <p>BG Yeah.</p> <p><b>Preceptor 5E:</b> Really, that's as much as..., I know that the concentration levels are not always, as high as...</p> <p>BG Yeah.</p> <p><b>Preceptor 5E:</b> As you could normally expect, and you need..., sometimes have to have like a quieter area...because otherwise, the..., you become a bit muddled, and...digest the information correctly. I don't know if that's right, but that's what I understood it as.</p>	<p>Describes that people with dyslexia see written forms in a different way</p> <p><u>Considers dyslexia initially as a visual difficulty</u></p> <p>Then states that's as about as much as I know, but then mentions that concentration levels are not always as high</p> <p>Comments on the need for a quieter area for nurses with</p>	<p>See written forms in a different way</p>
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<p>BG Where..., where did you get that information, is it something you picked up, or just.....?</p> <p><b>Preceptor 5E:</b> It's just from different people that I've actually you know, I've met different students...that had, dyslexia, and how they..., you know, what they've actually said to me...and how it affects them...and also, Olivia as well...</p>	<p>dyslexia as they can become muddles and not digest the information correctly</p> <p><u>Adds further detail about her knowledge with direct reference to nurses with dyslexia need for a quieter area</u></p> <p>When questioned on where she obtained this knowledge from, she refers to previous students who had dyslexia and told her how it affects them</p> <p><u>This knowledge appears to have developed through her own experiences working with nursing students with dyslexia, therefore contact experiences directly with those who have dyslexia appears to shape her knowledge</u></p>	<p>Need to have a quieter area, otherwise can become muddled</p>
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## Interview with Preceptor 6F

<p><b><u>Interview 1, Preceptor 6F, p. 1-3</u></b></p> <p><i>BG: To start off with, what do you know about dyslexia?</i></p> <p><b>Preceptor 6F:</b> Well, what do you want to know, the facts I know about it?</p> <p>BG: Yeah</p> <p><b>Preceptor 6F:</b> So, I did learn about dyslexia when I did my Postgraduate Education Certificate, there was a module on that, where we did learn about it, and how that affects students learning, and so I suppose I know a little bit, I know there's different types of dyslexia...</p> <p><i>BG Yeah.</i></p> <p><b>Preceptor 6F:</b> I know that people get words mixed up, they have trouble with sentence construction, paragraph constructions...spelling, there's types of dyslexia where you can't..., the words, if they're vertical, you can read them, the</p>	<p>Reveals she learnt about dyslexia when she did her PG Cert Ed where she did a specific module where she learnt about dyslexia, it's impact on student learning as well as different types</p> <p><u>Clearly attending a specific course with specific content on dyslexia has increased her awareness and knowledge</u></p> <p>Gives further details on her knowledge of dyslexia_such as</p>	
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<p>lines... but if they're horizontal, you can't read them...</p> <p><i>BG Yeah.</i></p>	<p>sentence construction, spelling etc., as well as specific types with specific difficulties.</p>	<p>Words mixed up, trouble with sentence construction</p>
<p><b>Preceptor 6F:</b> And there's types of dyslexia where you need to have..., the background of the page needs to be a different colour...so you can put either, transparents...green or blue, yellow, and also you can get glasses, which enable...which makes the words stop jumping about on the page.</p> <p><i>BG You can indeed.</i></p>	<p>Details specific types with regard to different coloured paper and use of transparents and glasses to stop the words jumping about on the page</p> <p><u>Identifies a specific type of dyslexia with use of colours, known as Irlens syndrome</u></p>	<p>Different coloured transparents stops words jumping around page</p>
<p><b>Preceptor 6F:</b> And so I suppose there's different types of dyslexia, and I've named some of those different types...that's about all I know really, I mean, there's other types of dyslexia, whereby people can't process</p>	<p>Details further different types with regard to not processing information quickly enough_which</p>	

<p>information quickly...they can't read quickly...they can't write quickly, as other people might do, and also that they can't write as they're doing, they find it difficult to transcribe...things that they're doing...</p> <p>And so they have to do everything..., write everything retrospectively, or perhaps if they can type it, it's easier than if they write it by hand.</p>	<p>results in difficulty in transcribing information</p> <p>Mention of dyslexics having to write retrospectively and typing is easier than writing by hand.</p> <p>Demonstrates an advanced knowledge of dyslexia in comparison to other preceptors.</p> <p>Do all PG Cert Ed courses have dyslexia in their curriculum content?</p>	
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**Initial Theme Q – Experiences of Being a Preceptor to a Nurse with Dyslexia**

## Interview with Preceptor 1A

<p><b><u>Interview 1, Preceptor 1A, p. 2,3</u></b></p> <p><i>BG: So, as a Preceptor to Emma who is dyslexic, can you tell me a bit more about those experiences in terms of supporting her, what..., what your first reaction was, and how you sort of dealt with it, any..., any particular issues, or...?</i></p> <p><b>Preceptor 1A:</b> Well, we made sure like, I created this kind of like grid...</p> <p><i>BG Yeah.</i></p> <p><b>Preceptor 1A:</b> And we called it a Bay sheet and it was a basic thing, to kind of break down all of her work, it was like...a brown piece of coloured paper...so that she found it easier to look at...</p> <p><i>BG Yeah.</i></p>	<p>Described the creation of a 'Bay sheet' to break down all of her work on a brown piece of coloured paper, which made it easier for her to look at</p> <p><u>Interesting that he designed it on a brown piece of paper specifically for her needs, showing consideration to her difficulties</u></p>	<p>Designed grid on coloured</p>
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<p><b>Preceptor 1A:</b> And it was split into six little grids...and then she would be able to write about patients' like temperature, BP, pulse etc. and things like that, and it helped her concentrate a little bit more about on what patients needed, at what time.</p> <p><i>BG Was that something you created yourself, purely for..., for Emma, or is that something..., something you...?</i></p> <p><b>Preceptor 1A:</b> It was something that I created for the unit...Because they're quite a big unit... we get a lot of patients in at different times, and I just thought it would help the flow of the ward as well.</p> <p><b><u>Interview 1, Preceptor 1A, p. 3-5</u></b></p> <p><i>BG Was this the first time you were a Preceptor to a Nurse with dyslexia?</i></p> <p><b>Preceptor 1A:</b> Yeah, it was, yeah.</p>	<p><u>around her specific type of dyslexia</u></p> <p>Explains further the design of the grid and how it would be used by Emma to aid her concentration in terms of what patients needed</p> <p>Describes that the grid was a resource that he created for the unit and how he felt it would help the flow of the ward</p> <p><u>Interesting that he designed the grid for the unit as well as for Emma's needs. A resource that is dyslexia friendly can also be useful to non-dyslexic nurses within a clinical area</u></p>	<p>paper to make it easier for the nurse</p>
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<p><i>BG The first time you've been a Mentor or Preceptor to anyone with dyslexia?</i></p> <p><b>Preceptor 1A:</b> Yeah,</p> <p><i>BG What was your first reaction when she said, "Look, I've got dyslexia" what were your first thoughts?</i></p> <p><b>Preceptor 1A:</b> I didn't really know really, she didn't let on to me, she didn't TELL me as such, that she was... and it was only when she was wearing her glasses, that I...asked her what her glasses were for, and she said, "Oh, I've got dyslexia, and I do find it hard"</p> <p><i>BG Yeah.</i></p> <p><b>Preceptor 1A:</b> And I was..., I was a bit ashamed that I didn't actually know that, to be honest...but after that, we kind of just tried to..., kind of tried to just put things into action.</p>	<p>Describes that he didn't really know she was dyslexic as she didn't inform him and it was only when he noticed she was wearing her coloured tinted glasses that she told him</p> <p><u>Those with dyslexia that do wear coloured glasses make it much more visible and therefore are more likely or at liberty to disclose their dyslexia when someone</u></p>	<p>Didn't know about dyslexia until he enquired about glasses</p>
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<p><i>BG OK, So, your..., your first initial thoughts, you..., you actually felt, you said you were ashamed you didn't know.</i></p> <p>Yeah, yeah I was, I was a little bit, quite ashamed I..., I didn't notice, because, she was my student, and I felt like I was supposed to be there for her, and I felt like I'd let her down in some respect.</p> <p><i>BG Did it cause you any concerns, when...?</i></p> <p><b>Preceptor 1A:</b> It didn't, and actually, she just got on with it quite well, she just...coped with it.</p> <p><b><u>Interview 2, Preceptor 1A, p. 5-8</u></b></p> <p><i>BG I asked you about your first reaction, when she said, "Look, I've got dyslexia" and I asked you what your first thoughts were, you said you didn't really notice really, but</i></p>	<p><u>enquires why they are wearing the glasses. Might be viewed as a physical evidence of a disability, in this case, dyslexia</u></p> <p>Describes that he felt ashamed that he didn't know and afterwards tried to put things into action</p> <p><u>Surprising reaction of shame when he realised that she was dyslexic, that he didn't know. Argue how could he have known, apart from the presence of the glasses</u></p> <p>Describes here a sense of responsibility that 'she was my student' and felt shame that he didn't know and had let her down</p> <p><u>Sees his responsibility in the context of a sense of duty and responsibility of supporting a nurse with dyslexia</u></p>	<p>Ashamed didn't know she was dyslexic</p>
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<p><i>you actually said you were a bit ashamed, that you didn't know...</i></p> <p><b>Preceptor 1A:</b> Yeah.</p> <p><i>BG Which intrigued me a little, in terms of that emotion, you used that word 'ashamed' in that sense, that...</i></p> <p><b>Preceptor 1A:</b> It was just because, I think it was..., it wasn't late on in the placement...but it was probably about six weeks into it...and I <b>just felt ashamed, not..., that I didn't know my student well enough, on a personal level, to help her out before, and...and that's..., and now, like when I do have students, I like to get to know them, like, I don't...I don't like, [Chuckles], grill them or anything, you know what I mean?</b></p> <p><i>BG; Yeah.</i></p> <p><b>I make an effort with them, on more of a friendly level...so that they feel comfortable with telling me stuff...</b></p>	<p>Describes how she got on with it quite well and just coped with it</p> <p><i>Use of the term 'coped with it' perhaps indicates the 'it' is the dyslexia that she coped with almost viewing dyslexia as an entity that is to be coped with</i></p> <p>Comments further on his feeling of being ashamed when he Emma disclosed her dyslexia, that he felt</p>	
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	<p>he didn't know her on a personal level to help her out and he likes to get to know his students</p> <p><u>Identifies a sense of both responsibility and duty in getting to get to know his student and the importance of this</u></p> <p>Describes how he makes an effort so they feel comfortable with him</p> <p><u>Describes almost a paternalistic approach to the case of his students and nurses</u></p>	
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**Interview with Preceptor 2B**

<p><u>Interview 1, Preceptor 2B, p. 2-5</u></p> <p><i>BG You were a Preceptor to Holly who is dyslexic, can you tell me something about those experiences with her as a..., as a Preceptor...working alongside her?</i></p>		
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<p><b>Preceptor 2B:</b> She did..., she did tell me that she'd got dyslexia, when we first started, obviously...in the training...</p> <p><i>BG Yeah.</i></p> <p><b>Preceptor 2B:</b> She..., she didn't really disclose too many things, but she just had this little book with her...and she used to write things down, in her way...and if I was like doing some questioning with her...and then she used to write things down in her way...</p> <p><i>BG Yes.</i></p> <p><b>Preceptor 2B:</b> And, if I was like doing some questioning with her, like maybe over medication things... she would just say, "Can I refer to my little book?" and I was like, "Yeah, course you can" like, you know... I have no problem with that.</p> <p><i>BG Sure.</i></p>	<p>Commented on how Holly wrote things down in her little book, often a common methods used by dyslexic nurses to remember things</p> <p>Describes how Holly would ask her whether she could refer to her little book when questioned over such things as medication and comments she had no problem with that</p>	<p>Always had notebook to write things down</p>
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<p><b>Preceptor 2B:</b> And..., and that's the only thing really, that I can... remember her doing...she always had this book in her pocket, a little notebook...</p> <p><i>BG Yeah.</i></p> <p><b>Preceptor 2B:</b> And wrote things, obviously, the way she could understand it... and that's fine, because as long as you can do your job...it doesn't really matter...that you can..., that you have to refer to your little book, I..., I've got things that I refer to, so...</p> <p><b>Preceptor 2B:</b> You know, I..., I don't..., I don't have a problem with that, I refer to things when it comes to maths, I can't remember all the maths calculations...</p> <p><i>BG Of course.</i></p> <p><b>Preceptor 2B:</b> So, I get my little book out of my pocket, [<i>Chuckles</i>], does it really matter? As long as you..., you know, you get to the end-result... I haven't got a problem with that, I didn't see that as being a problem...with that at all.</p>	<p><u>Use of a little book to check things seen as perfectly acceptable by preceptor 2B, non-dyslexics might use similar as aide memoire's</u></p> <p>Comments that she has no problem with the use of a little book to remember things, as long as she can do the job it doesn't really matter, she has also things she refers to</p>	<p>As long as she can do the job, that's all that matters</p>
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<p><b><u>Interview 1, Preceptor 2B, p. 5-9</u></b></p> <p><i>BG: What were your first thoughts that went through your mind, when she informed you, or disclosed to you?</i></p> <p><b>Preceptor 2B:</b> Not really, because you have to work with the people...with..., with the.....I don't know the word to use; special needs?</p> <p><i>BG Sure.</i></p> <p><b>Preceptor 2B:</b> Maybe that's it, I..., I don't know, I haven't..., I don't have a problem with that.</p>	<p>Reiterates she doesn't have a problem with this, she gives an example she can't remember maths calculations. She states as long as you get to the end result, she doesn't have a problem with that</p> <p><u>Makes comparisons with herself over the use of strategies such as notebooks to remember things, so such simple strategies are used by non-dyslexics, which makes it more acceptable if recognised as someone she does also</u></p>	
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<p><i>BG Was this the first time you were a Preceptor to a Nurse with dyslexia, as far as you were aware.</i></p> <p><b>Preceptor 2B:</b> She was my first Nurse...</p> <p><i>BG Was she? OK</i></p> <p><b>Preceptor 2B:</b> So, yes, I suppose in a way she was. I have worked with other students...but not in a Nurse..., like me, as a Preceptor to Nurses...</p> <p>BG Sure.</p> <p><b>Preceptor 2B:</b> Many years ago, I worked at a college... I worked there 16 years... And I started the NVQ up... I'd got 16 years of disability...awareness anyway, so, I'm quite happy to work with people like that...</p>	<p>Comments that you have to work with people with (hesitates), special needs</p> <p><i>Grapples with what word to use, finally using special needs/ Almost perhaps detects some stigma connected to the word, special needs</i></p> <p>Clearly states she doesn't have a problem with that</p> <p>States she was her first nurse with dyslexia she supported as a preceptor</p> <p>Comments that she worked in a college for 16 years with students with disabilities, thus has a lot of disability awareness and is happy</p>	
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	to work with people with disabilities	
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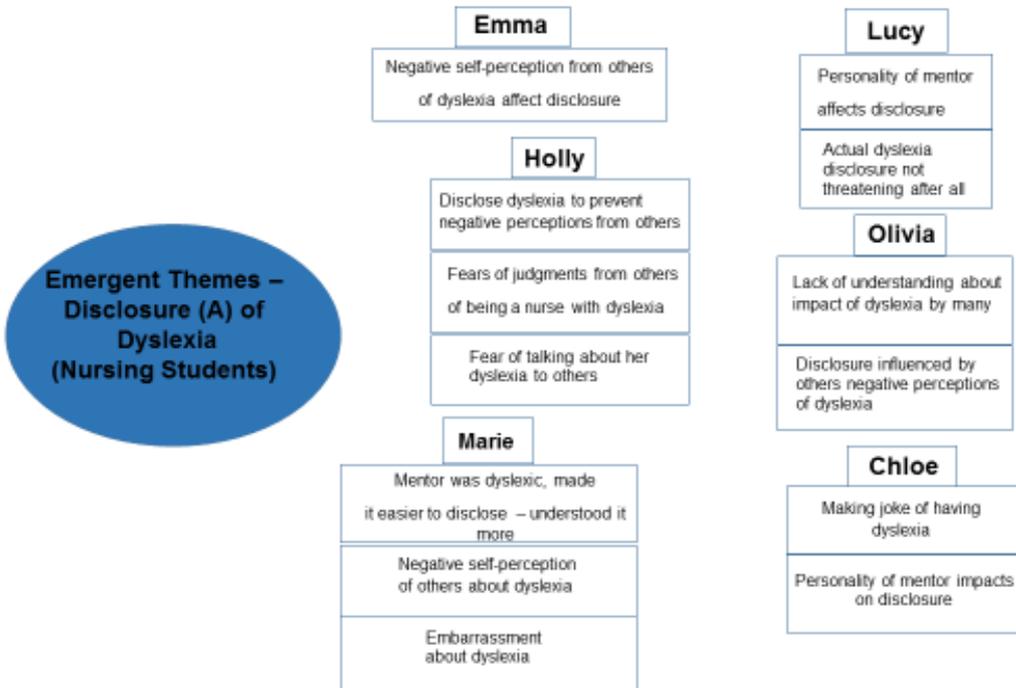








# APPENDIX 17: Nursing Students – Emergent Theme Diagrams



**Emergent Themes of School Experiences (B) (Nursing Students)**

**Marie**

Fear of reading out loud – fear of disclosure
Extra lessons made her feel less isolated
Fear of disclosure as she became older

**Emma**

Lack of recognition of difficulties in school
Anger dyslexia wasn't picked up at school
Negative school experience affected career choice

**Lucy**

Early diagnosis at school meant early support
Initial embarrassment about dyslexia
Others needing support lessened isolation

**Olivia**

Diagnosis at early age made no difference
Extra lessons gave a feeling of isolation
Anger & frustration over negative teacher reaction
Hate idea of being different

**Holly**

Lack of recognition of difficulties at school
Resultant impact of lack of interest
Single 'lightbulb' moment of return to education

**Chloe**

Frustration over difficulties at school
Purposely picked less writing type subjects
Questioned my own intelligence and ability

**Emergent Themes of Drug Administration (C) (Nursing Students)**

**Marie**

Difficulty if patient asks me what drug is for
Difficulty in pronunciation of drug names

**Emma**

Paranoia of checking and checking
Great fear of making a drug error
Dyslexia increases awareness of making errors

**Holly**

Fear of making a drug error
Constant checking of drugs takes me longer

**Olivia**

Difficulties in reading written prescriptions
Has become more familiar with frequent drugs

**Chloe**

Difficulty in lining up boxes across chart
Pronunciation of drug names a difficulty
Non-dyslexic nurses have difficulty with drug pronunciation

**Lucy**

Difficulty pronouncing drug names
Fear of saying drug names out loud
Always double and triple check drugs

**Emergent Themes of Documentation (D)  
(Nursing Students)**

**Emma**

Embarrassed of other people reading my documentation

Difficulty with new words

Visual learner helps me remember words

Remembering instructions and writing it down

**Lucy**

Fear of not being able to spell a word

Fear of reaction to spelling from others

Fears of others reading my writing

Frequency & familiarity of writing increases confidence

**Marie**

Writing out spelling first before on main documentation

Use of google to check spelling words

**Chloe**

Writing out first before on main documentation

Gets someone to check it first

Takes me longer to write

**Holly**

Difficulty of getting words from head to page

Use of quiet area to help her write

Fear of looking stupid to others

**Olivia**

No extra time in placements to write documentation

Writing things out twice to avoid spelling errors

Fear of others over her writing

Frequency of seeing regular words helps

**Emergent Themes of Self-Perception of Dyslexia (F)  
(Nursing Students)**

**Emma**

Low IQ self-perception of others

Embarrassment of differences to others

**Lucy**

Perceives others think can't do normal day job

**Holly**

Embarrassment of what others might think

Self-perception of others thinking I'm 'thick'

**Olivia**

Self-perception of others thinking I'm 'thick'

I'm the same as them

**Chloe**

Others don't think I'm clever enough

Fear of others thinking I'm an idiot

**Marie**

Negative self-perception of her abilities to be a nurse

Nurses are clever, I'm not

**Emergent Themes of Clinical Handovers (E) (Nursing Students)**

**Emma**

- Use of timeline in handovers to remember
- Difficulty keeping up in handovers causes embarrassment
- Use of visual cues to read my handover notes

**Lucy**

- Worry of reading out at handovers
- Fear of reading others handwriting
- Fears of others watching her

**Marie**

- Fear of reading out in front of others
- Checking word meaning before reading out
- Fear of what others think of her

**Holly**

- Difficulty in pronunciation of words in handover
- Embarrassment of what others might think

**Olivia**

- Purposely Avoiding doing handovers
- Fear of speaking out loud in front of others

**Chloe**

- Difficulty of following lines across a page
- Non-dyslexic nurses difficulty spelling drug names
- Embarrassment of being laughed at in handover had impact

# APPENDIX 18: Registered Nurses – Emergent Theme Diagrams



**Emergent Themes – Disclosure of Dyslexia R.N. (B1)**

**Chloe**

Senior nurses need to know

Only disclose if I have a problem

No-one needs to know

**Emma**

Presence of glasses means has to disclose

Self –perception of negative feeling of others

Disclosure of dyslexia gives reason why I'm slow

**Holly**

Only disclose when appropriate

Disclosure appropriate to explain slow thought processes

Disclosure to avoid been seen as 'useless'

**Lucy**

Disclosure of dyslexia is ok.

It is who I am

Everyone knows at work, it doesn't show

Doesn't bother me

**Olivia**

Don't disclose unless I have to

Will disclose if I can't spell word

Presence of glasses means has to disclose

**Marie**

Helpful mentor initiates disclosure

Non-disclosure as I don't want to be treated differently

**Emergent Themes – Familiarity of Nursing Tasks R.N. (C1)**

**Emma**

More knowledge I have, more I prioritise

**Holly**

Things become more automatic

Dyslexia now on the back burner

More I do, more things fall into place

**Chloe**

More used to the struggle

Getting easier as I'm getting used to it

**Lucy**

Familiarity of drug names easier now

Drugs much easier as an R.N.

**Olivia**

Structured routine helps

Repetition helps

**Marie**

Names of conditions more easier due to frequency

**Emergent Themes – Drug Administration R.N. (D1)**

**Emma**

Constant checking of drugs

Confusion over similar sounding drug names

Would normal person make same mistake?

**Lucy**

Double check the spelling in Dr's writing

Double, triple times check, but others do it also

**Olivia**

Paper documentation more difficult to read – Dr's handwriting

Computer system with drugs easier for me

Paranoid – over check everything

**Holly**

Check, check and re-check

Double check Dr's writing

Non-dyslexic nurse would also double check Dr's writing

**Marie**

Write down drugs so know them for next time

Checking drugs at least once

Use of google to check drugs

**Chloe**

Difficulty matching boxes across the chart

Difficulty with similar sounding drug names

**Emma**

Difficulty keeping up in handovers

Embarrassing to stop handover to check what's been said

Difficulty with pronunciations – embarrassed

Reading out to others makes me very nervous

**Lucy**

Nothing has changed with handovers

**Olivia**

Can't avoid handovers now

Have to slow down

'Absolutely awful' when did my first handover

**Holly**

More confident with handovers

Embarrassment over pronunciation of drugs

Lots of others can't pronounce it

**Marie**

Difficulty with pronunciation with words

Fear of handing over to others

Negative reaction from others in handover

**Chloe**

Missing bits out – not reading it properly

**Emergent Themes – Clinical Handovers R.N. (E1)**

**Emergent Themes – Documentation R.N. (F1)**

**Chloe**

Difficulty spelling technical jargon
Other nurses struggle with spellings
My handwriting illegible
Write more neatly when patient particularly sick

**Emma**

Visual cues to help me write
Take more time over documentation
Need quiet area to write
Use of triggers in documentation

**Lucy**

Make sure it makes sense
No-one to proof read it
More complex words easier now

**Olivia**

Told if you can't spell it, don't write it
Challenged over inability to spell

**Holly**

Don't need a quiet area anymore
Blank out what's around me
Read through what I've written

**Marie**

Difficulties with spelling
Difficulty reading others writing
Conscious of others reading my writing

**Emergent Themes – Self-Perception of Dyslexia R.N. (G1)**

**Emma**

Worry about what others think
Feel I'm letting the team down
Trapped in my dyslexia

**Lucy**

Dyslexia doesn't bother me anymore
My manager being dyslexic makes it easier

**Olivia**

Don't want an error be seen as it's because she's dyslexic
It's because I'm human, not because I'm dyslexic
If ever made an error, they would blame my dyslexia

**Holly**

Can get easily bogged down in your dyslexia
Don't be ashamed of your dyslexia

**Marie**

Feel I'm a burden to them
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**Chloe**

Makes you stand out as 'not normal'
Not being perfect makes you more aware of mistakes you can make
I'm definitely not perfect





