Manuscript accepted for publication in Nurse Education in Practice on 18th June 2019

Nurses' experiences of learning to care in practice environments: A qualitative study

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Highlights

- Nurses prioritise highly nuanced care under substantial time pressure.
- Caring is often regarded as "going the extra mile" in nursing practice.
- Student nurses have high levels of commitment, caring attitudes and behaviours.
- Delivery of personalised care is linked to emotional awareness and regulation.
- Strong theoretical links between resilience and caring behaviours are indicated.

Abstract

Introduction

Recent attention has been drawn to the absence of caring behaviours in health services globally, termed a "crisis of care" and policies are developing to address this shortfall. To obtain accounts of caring behaviours and attitudes in nursing practice and to identify how nurses manage student learning, we spoke to nurses and students in university and hospital locations across 2 NHS England Regions.

Method

Using the principles of appreciative inquiry, we conducted focus groups with BSc and MSc pre-registration nursing students, mentors, link lecturers and practice educators (n = 69).

Findings

Participants spoke powerfully about skilful, caring nursing practice, identifying plentiful examples of caring behaviours and attitudes. Four main themes emerged: "going the extra mile" (beyond routine policy, demanding commitment, flexibility and adaptation); time spent or invested (moderated by personal or organisational resources); caring as a personalised experience; communication practices and culture/role modelling.

Discussion/conclusions

Positive caring attitudes and behaviours shown to patients, staff and work were highly valued. An ability to regulate and sustain an emotional connection with patients framed student learning. Observations of nurses who preserved caring practices amidst organisational pressures were frequently chosen by students as role models who "fight" inadequate or missed care. Theoretical links between caring and resilience are strengthened by these findings.

Introduction

Much has been written about poor attitudes to caring in health services where undesirable caring behaviours are commonplace. Nursing research in this field has portrayed nursing care delivery as either focussed on technological nursing or softer non-life saving skills. This paper presents the second arm of a larger study which sought to describe how student nurses learn to care. The first arm of the study analysed qualitative data from practice assessment documents kept by students and their mentors for those enrolled in BSc and MSc pre-registration adult nursing programmes. We found that students prioritised a holistic, melded approach to caring, where students and mentors valued combining softer skills with highly technical skills using flexible, tailored methods to provide optimal personalised care (Young et al.,2018). In this paper we report on the findings from the second arm of our study: focus groups with pre-registration adult nursing students, mentors, practice educators and link lecturers using an appreciative inquiry approach. When asked to discuss examples from clinical practice where staff really cared about their patients and strategies to embed caring, four main themes emerged: caring as going the extra mile and spending time, personalised caring through relationship, and caring demonstrated through communication and mediated by culture. These findings add important perspectives for nurse education in light of examples demonstrating the dominance of a culture of caring given by our participants.

Literature review/background

Patients say they want caring and competence from staff (Goodrich and Cornwell 2008). Patients view compassion as inextricable from nursing actions (UK Patients Association, 2012) and acknowledge that whilst compassionate care can take lengthy periods of time, compassion may also be demonstrated by nurses in actions that are fleeting(Bramley and Matiki, 2014). However, there has been a tendency in the literature to focus attention on an absence of caring, and associated deficits in attitude (e.g. Doyle et al, 2014) or organisational context (e.g. Stone et al., 2011). Barriers to caring attitudes and behaviours include: resource shortage (Maben, 2008;Paley, 2013), delegation of fundamental nursing to HCAs and increasing specialist nursing roles(Maben et al., 2006, O'Driscoll et al, 2010), educational deficits (Darbyshire and McKenna, 2013) and instrumental managerialism (Feo and Kitson, 2016). Less attention has been paid to the theoretical perspectives which might help elucidate the complex interaction between context and response (Paley, 2013; Roberts and Ion, 2015). Concern sexist about the consistency in quality of clinical placements and the effect on student nurses' learning (Skaalvik et al, 2011; Thomas et al.,2015; Willis, 2015). The theory–practice gap is an ongoing global concern (Maben et al., 2006;Scully, 2011) and research is needed to explore how students ‘progression through practice influences person-centred care (Currie et al., 2015). Further exploration of the unique learning potential for students from clinical environments is also timely given the international move towards more simulation based and blended teaching and learning methods (see for example, Cant and Cooper, 2017;Loke et al., 2017). This study explored how students, mentors and educators linked positive caring attitudes or behaviours with everyday nursing practice (Reynolds et al., 2006; Darbyshire and McKenna, 2013).

Method

We conducted focus groups across 6 separate cohorts of pre-registration nursing students in BSc (3 groups, n = 18) and MSc programmes (4 groups, n = 17). Students were recruited using convenience sampling. Researchers introduced the study in lectures with cohorts of students with whom they had no teaching or assessment relationships and who were on campus during the recruitment phase of the study. Focus groups with mentors (2 groups n = 17) and practice educators with link lecturers (2 groups n = 17) also took place. To generate interest from these groups, posters and emails were distributed to practice areas. To

preserve the confidentiality of participants, interviews and focus groups took place in rooms away from teaching, clinical and office space between August 2014 and July 2015 by five facilitators with qualitative research experience. We sought to understand examples of caring in everyday nursing practice using appreciative inquiry; a philosophical approach which aims to identify good practice and focus on what works rather than what doesn't (Bushe, 2011; Watkins et al.,2016). To enhance the trustworthiness, initial interviews were con-ducted in pairs, with a facilitator and observer. Interviewers sought contemporary accounts of "good examples of caring" in nursing and strategies which enabled these. Students were also asked to discuss how the experiences would influence their future practice. Although our philosophical stance was appreciative inquiry, participants were able to discuss any situations they chose. Interviews and field notes lasted between 40 and 75 min, digitally recorded, stored securely and transcribed verbatim.

Ethical considerations

Approval was given by the University Research Ethics Committee. Researchers who had no academic responsibilities for learning were allocated to students to ensure informed consent, freedom from coercion, the right to withdraw, anonymity and confidentiality. Interviews occurred in private locations.

Participants

Volunteers varied by age, gender, ethnicities, and qualifications, according to population. Students were interviewed within cohorts at different programme progression points. Mentors and educators were qualified for varying lengths of time and worked in diverse settings.

Data analysis

Analysis was conducted according to Braun and Clarke (2006) 6 step process as follows. Transcripts were read and re-read to familiarise researchers with the data; initial coding was performed and themes emerged individually by focus group. Transparency, dependability, and confirmability was established by reviewing the themes as a team, first by focus group and then across all transcripts. Reflexive discussion enhanced final theme definition, which were identified co-operatively. Finally, we held a workshop for participants', additional practice staff, lecturers and students to member check for meaning and credibility, enhancing the trustworthiness of our findings, before writing up (Clarke and Braun, 2013).

Findings

Through our process of data analysis, four main themes emerged: "going the extra mile" (beyond routine policy, demanding commitment, flexibility and adaptation); time spent or invested (moderated by personal or organisational resources); caring as a personalised experience and culture/role modelling. We also found particular ways that our participants expressed their ideas about caring across all of these themes: that students were keenly observant and passionate about caring in practice, the impact of an inspirational nurse to participants was clear, and that despite using an appreciative approach, our participants often contrasted good caring with poor examples to give voice to what they viewed as positive caring attitudes or behaviours within everyday nursing practice.

Going the extra mile

Students discussed going above and beyond in all our focus groups as behavioural and attitudinal:

"It wasn't just what you were taught to do, everybody has gone that little extra mile of what you can't be taught … that feeling you have inside you, it's that empathy" Sam, BSc year 2.

This was illustrated across our focus groups with great variety.

Examples included talking and being friendly, teamwork, attention to detail, spending extra time with patients and buying small items for patients. This usually involved having specific knowledge about individuals, hearing and respecting patient choices and tailoring caring to each patient:

"Every time, the radio, while we are giving her personal hygiene, would be switched off. She would be … very moody … I would go to the room and ask her, "How do you feel? Would you like the radio to be on?" So things would go much better and …. they would always make sure she had her radio on … Simple steps but they have a big impact." Nirmala, BSc year 1.

This tailored, adaptive approach was also highlighted as "extra" caring in relation to organisational flexibility. One participant told the story of a needlephobic patient who needed injections every couple of weeks;

"so we would hold the needle in A&E and every time she needed it she'd get blue lighted and give it to her straight away" Caleb, BSc Year

Many students discussed tea-making as a highly symbolic "extra" caring activity. When attempts were made by other staff members or by rules in the clinical areas to constrain it, they broke the rules:

"This gentleman was in his last few hours, his wife and daughter had been there for hours, hours and hours, and all they wanted was a cup of tea… so I made one and I was chastised for doing so …" Grace, BSc year2.

Students spoke about good caring examples of going the extra mile when nursing role and shift times were extended for patients. This involved staying late after a shift in order to complete an episode of care for a particular patient, coming in early to organise their workload for the day or leaving late having prioritised patient care before completing notes after their shift time had officially finished. However, while this form of "going the extra mile" was widespread to all in our focus groups, it was also seen as controversial. Some argued that caring conceptualised as "extra" devalued genuine caring activity, whilst others saw the opportunity to align caring with their personal values.

Unsurprisingly, it was the link lecturers and practice educators who highlighted the potential impact of this on stress levels, work life balance, and expectations, identifying potential issues with managing workloads, taking breaks and leaving work on time. A practice educator also saw her role was to set an example of how to go the extra mile, while managing time effectively and looking after yourself.

"I think we have to be careful about going the extra mile … What is it that's throughout the day that leads to you staying? … It all impacts on care and then it impacts on yourself with your personal life and your

work life, so it's getting the balance … how we set an example at work"
Florence, Practice Educator

Time

Our participants saw time spent talking with patients and families as an important, but sometimes problematic, caring activity. Some students included talking as an "extra": "… just to have a chat with her and reassure her rather than doing a task that she had to …" Kelly, MSc Year2. Others saw talking with patients as an opportunity to provide emotional and social caring which did not always have to cost time but could be done along with physical tasks, for example, when washing patients or changing their position. Our participants discussed continuity over time as better, individualised care:

"You can see how they were compared to the day you worked before and be like 'Oh, they don't really look right today' or they're much quieter than usual, then you know that something's wrong, that you need to like investigate" Elizabeth, BSc, year 3.

Our participants grappled with seeing their colleagues trying to care despite time constraints and the reality of resource strapped clinical environments, identifying multiple negative consequences. These included nurses concerned about patient safety, safe practice (particularly in relation to administration of medicines), colleagues not able to take breaks and some even off sick with stress.

"It was just ridiculous … she was so passionate about the caring … the pressure was unbelievable …" Gita, BSc year 1.

However, there were also examples of positive learning from experienced nurses who continued to care while managing these challenging environments. An experienced, calm mentor was particularly inspiring in seemingly chaotic, out of control environments;

"she went 'It's going to be all right …. I want you to learn something, in nursing you will come on a shift when it's like this but everything will happen so you just need to calm down…go to the patient and get on with it and we will get there'. That is a caring person." Carol, MSc year 1.

In resource pressured situations, the challenges of having good quality mentoring were acknowledged by all of our focus group participants, but particularly the link lecturers who pointed out that hard pressed nurses do not always have the capacity or experience for effective mentoring. For the most part, the students felt positively received and the practice areas were grateful to have them. The students were acutely aware of their supernumery status and what they could contribute to caring in such environments. Some even sought solutions to the constant pressure.

"Even though we are working under resourced … are we giving the quality care for the patients or are we just ticking a box? Are we treating them as an individual or are we really missing the biggest concept of care? … I want to make a difference because I came and took nursing because I care " Alice, BSc year 1.

Personalised experience

Prioritising patient centred care and relationships was seen as high quality caring. This included responding to and prioritising individual patient's emotional needs, particularly when they expressed any worries or anxiety. Our participants also felt that getting to know patients individually was key to delivering patient centred, compassionate care:

"I think the littlest thing … is knowing your patients … they can tell you about her, like, family … her condition, treatment options, everything … it helps you as a family member know that they're being looked after and it helps other staff members know that you are competent in your job and you're caring and compassionate" Nita, BSc year 1.

They also discussed learning how to make personalised, positive,caring relationships through watching the actions of nurse leaders:

"The senior sister she was very good, she would come in in the morning …talk to all the patients, see if they've any concerns and…then she'd do it before she left. So any concerns that patients had they'd see the sister frontline, she'd just go round and speak to every one of them."
Elizabeth, BSc year 3.

Mechanisms for achieving good relationships included touch, personalised care, talking, being unrushed, reassurance, and comforting and friendliness while maintaining professional boundaries. Sometimes relationship was discussed in a functionally productive way:

"I'm still reassuring the patient that I'm here … build the relationship … which would make your lives easier, both your patient and yourself"
Steve, MSc year 1.

Students saw merit in sharing some personal information about themselves as a way of building relationships, for example, talking about their children or careers, and were disappointed when they saw diminished relationships, especially if this was in the form of prioritising tasks, such as completing documentation, at the expense of getting to know patients. Communication was seen as significant and information sharing and listening to patients was frequently interpreted as good caring. Developing skills and confidence for patient advocacy was particularly important to final year students, whereas students newer to nursing emphasised the need for self-awareness:

"There was a man had dementia, and he said I seemed suspicious, I didn't mean to come across that way … I realised that I had to be aware of how I was being because it impacted on their like, the care they were receiving."
Freya, 1st year MSc

Culture/role modelling

Our participants discussed work culture as a central feature influencing their ability to be caring. This included the overall atmosphere on the ward (which one student termed 'the vibe'), and whether it felt calm and controlled or hectic was viewed as a barometer of whether or not you could trust in the nursing care on the ward. Handover was discussed as a powerful marker of the culture of caring on a ward. In one particularly lengthy discussion, students highlighted negative examples of uncaring cultures they had seen during nursing handovers. These included embarrassing patients by talking over them, regular breaches of

confidentiality by sharing information in the public space of the ward - sometimes about highly personal health issues and bodily functions, and depersonalising patients by referring to them as “just a name on a sheet of paper”.

It was not necessarily individuals that were seen at fault, but the whole team and what behaviours were deemed to be acceptable;

“Everybody has to genuinely care rather than have this attitude against people” Shelagh, MSc year 1.

The role of the senior nurses and ward manager was pinpointed as significant to cultures of caring. Participants differentiated between leaders who contributed to the day to day running of the ward, talking to patients, actively delivering care to patients (such as washing and repositioning patients) and ‘mucked in’ with the team, as opposed to those that were focussed on administrative tasks, stayed in their offices and did not take any part in the frontline delivery of care.

Students commonly experienced poor cultures of caring with confused patients and wanted to be caring, but this was difficult. There was a perception that often they were the only ones caring which they did, sometimes in spite of both individuals and work cultures who discouraged their efforts.

“She was crying in the night and the nurse said ‘Just ignore her, just leave her alone’ … I did ignore what the nurse told me … I just spoke to her, held her hand” Shelagh, MSc year 2.

Along with seeming uncaring attitudes towards confused patients, students also expressed a perception that a reduction in caring when qualified and overtime was inevitable. For example, one student felt that when she took extra time to communicate with and be kind to

confused patients, it was seen by others on the ward as

“a kind of naïve thing, you know, you'll get over that once you're qualified” Sian, BSc year 2.

Students tried to challenge poor caring cultures, but weren't always successful. This included questioning colleagues and even mentors about the way they were caring for patients. One example came from a student who explained that she felt she had to manage a situation where her mentor was not communicating in a caring way for a patient. On reflection, the student recognised that there was strength required to challenge poor practice, particularly of your mentor, but in the end it was worth it for patient care.

“I think that between healthcare people, if really we fight for caring I think that we can at least try to raise up the standard” Jamal, BSc year 2.

Discussion

A recurring theme across our focus groups showed that student nurses allowed themselves to be emotionally and practically moved by patients' situations, often in their own time, which we term ‘going the extra mile’. Our work elaborates the work of Solvoll et al (2010) who noted an initial emotional call to caring when they observed and interviewed 6 student nurses working in practice. This is, in itself, a difficult and controversial area for nurses to learn to negotiate in practice. Indeed, some of our qualified nurse participants sought to empower their colleagues to handover caring work at shift end. Others idealised the self-

sacrifice involved and recognised this as a caring way to behave (though problematic with risks to health and wellbeing).

In a metanarrative, Sinclair et al. (2017) convincingly report that all nurses were susceptible to work stress and associated detriment to health. However, nurses who provided exemplary caring were not found to experience more compassion fatigue than less caring counterparts. This is encouraging because our participants provided many examples of caring from clinicians in placements. Importantly, while our methodological frame of appreciative inquiry emphasised positive learning experiences, we found that students observed their colleagues' behaviours, particularly examples of negative caring, evaluated them, and turned them into what they saw as positive learning about how they would choose not to behave. Our work complements Janssen and Ene's (2016) findings that students particularly appreciate mentors who articulate caring decisions amidst heavy workloads and associated stress, but are realistic about the problematic nature of discussing care when busy. Our findings extend this: students are highly sensitive to negative caring experiences and often form their identity as a nurse through courageous insubordination to mentor instruction when this is perceived as uncaring and contrary to the expected values of nursing. These findings are in keeping with Bahn (2001) who noted that students will censure what they see, not automatically reproducing the behaviour of others if it offends their ethical standpoint, regardless of cultural norms. In our study, negative behaviours frequently acted as a strong motivator for independently responsive nursing care, particularly related to nursing handover and treatment of dementia patients. Bandura 2016 describes this as ‘vicarious re-inforcement’, whereby the observer watches the successes and failures of others, which both informs and motivates the learner (1971; 2016).

Caring as insubordination is sometimes learned by watching qualified nurses who challenge cultural norms. In complexity theory, this cultural rebellion would be akin to dissipative structure theory of change, in which organisational transformation occurs through myriad small disruptive influences acting synergistically to eventually re-orientate organisational and cultural norms (McMurtry, 2010). Those participants in our study who gave poignant examples of providing good care against cultural norms, are positive change agents. Care was given despite contrary policies, chastisement from colleagues and a lack of resources. Our participants demonstrated strong personal motivation and fierce determination to continue this insubordination in the face of depersonalising systems and work pressure. Participants often talked of ‘staying strong’ and ‘fighting’ to raise caring standards. However, participants across our focus groups agreed that learning occurs best in students when organisational structure is designed to support mentor-mentee educational wellbeing (Maben et al., 2006). Change management theorists would argue that management is also able to instigate change from the top down by unfreezing the cultural norms (Lewin, 1958), although Kotter (2012) argued that these changes have to occur in a responsive organisational system that makes use of its networks.

Our findings therefore support organisational investment in meaningful time for the mentor-mentee relationships (Bazian Ltd, 2016). Resilience has been defined as ‘the ability to overcome adversity and includes how one learns to grow stronger from the experience’ (McAllister and McKinnon, 2009). While much has been written by nurse scholars about resilience and its relationship with enhanced patient care, retention and job satisfaction, the connections have been elusive to establish in empirical research (Thomas and Revell, 2016).

Although resilience is not particularly well defined across the literature (Sanderson and Brewer, 2017), factors such as support, time and empowerment are important precursors to

student nurse resilience (Thomas and Revell, 2016). All of these factors are visible in our data.

Links have been made between resilience and emotional intelligence in student nurses. Kong et al (2016) identified resilience as a mediator in the relationship between emotional intelligence and communication by student nurses in clinical contexts. This also relates well to our findings.

Emotional intelligence is 'the ability to monitor and discriminate emotions of oneself and others and use this information to guide one's thinking and actions' (Mayer et al, 2008) and its use in nursing practice has been shown to promote effective communication and improve nursing performance (Lewis et al., 2017). Our participants described how they used their emotional response to patients as a guide for their caring actions, including maintaining calm in a chaotic environments, feeling sad when responding to a patient's call for help, and being driven by compassion to respond to patients. Our data thereby strengthens theoretical links between demonstrable caring behaviours, resilience and emotional intelligence in student nurses. This is significant for nurse educators globally, particularly given the recent links made between higher scores of emotional intelligence and completion of nursing degrees (Snowden et al., 2018).

These findings from the second, focus group stage of this research are very much in keeping with the first, which examined how student nurses learn to care through analysis of practice assessment documents (PADs) (Young et al., 2018). From the PADs, we found that both students and mentors valued combining softer skills with highly technologized care and flexible, tailored approaches which aim to provide optimal, personalised care. These findings were encouraging for nurse educators in a context of international scholarship in which the dominant narrative appears to be of fragmented, task oriented suboptimal nursing care. Most recently, pedagogical approaches to nursing education have been blamed for creating barriers through the use of reductionist approaches that have 'physically and cognitively separated the learning and teaching of knowledge, skills and ethical codes of practice' (Weeks et al., 2017). In contrast to this perspective, our focus group findings affirm students learning a melded, patient centred, individualised approach to care while driven by an underpinning ideology to fight for high quality nursing care and actively resist negative cultural influences in clinical environments. Our participants gave expression to this through watching and evaluating others attitudes and behaviours, learning from both positive and negative experiences, and by drawing on their emotional response to patients through a strong personal ethic of care.

Conclusion

Caring is clearly a complex multi-faceted activity carried out in challenging health care cultures and environments which can foster both negative and positive caring attitudes and behaviours. From our focus groups, we have found students not only willing to challenge the status quo and anti-caring cultures, but to use their experiences as motivation to resist and question those behaviours. To achieve this, they demonstrated resilience and a desire to maintain emotional connections with patients which, while counter to what they sometimes saw, was identified as an essential part of caring.

In England, the NMC have recently set out their goals for nursing education for the future:

"Registered nurses … work in the context of continual change,
Challenging environments, growing diversity and rapidly evolving

technologies. It is therefore essential that they are equipped with
the knowledge, confidence and transferrable skills needed to respond to these demands. (Nursing and Midwifery Council, 2017, p.3)"

Along with this vision, recent changes to NMC training standards see the removal of the cap on the amount of hours through which students can learn through simulation, and a new model for mentoring student nurses in both academic and clinical practice (Hoy & George, 2018). It remains to be seen how these changes will fully impact on nurse education in England, but our findings add to the international scholarship which emphasises the essential place of role models, mentors and situational learning experience for student nurses learning to care.