Caring behaviours:
The perceptions of first- and fourth-year nursing students

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Declaration

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: 29 September 2014

I, the undersigned, hereby declare that the work contained in this assignment is my original work and that I have not previously submitted it, in its entirety or in part, at any university for a degree.

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Date: 29 September 2014

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Abstract

Educators across the health professions are now concerned with the teaching and assessment of professional skills. Caring behaviour is one of the attributes of professionalism in the health sciences professions and in the nursing profession it is regarded as the essence of the profession. The aim of this study is to explore the understandings and experiences of caring behaviours of first- and fourth year nursing students and how they would like to be assessed about their caring behaviours in a curriculum where it is not overtly taught. This will be investigated according to Watson's carative factors and theoretical framework of caring, while Bloom's Taxonomy of the affective learning domain will also be consulted. The design of the study is qualitative and explorative. A purposive sample was drawn from first-year nursing students (n=64), and fourth-year nursing students (n=41) at one nursing education institution. The sample of students (n=105) from seven (7) private training hospitals in the Western Cape participated in nine (9) focus group interviews (n=10-15). Data analysis was done by means of a framework analysis approach with a deductive strategy. Research findings from this study are extensively discussed and will be used to inform the undergraduate nursing curricula in South Africa about the profiles of caring nursing students and to make recommendations about the internalisation of caring behaviours, according to the affective learning domain.

Opsomming

Opvoeders vanuit die verskeie gesondheidsberoepe, is tans met die leer en assessering van professionele vaardighede gemoeid. Sorgsame gedrag is een kenmerk van professionalisme in die gesondheidsberoepe. In verpleegkunde word sorgsame gedrag as die kern van die beroep beskou. Die doel van hierdie studie is om die begrip en ervarings van eerste- en vierde-jaar verpleegkunde studente rondom sorgsame gedrag te ondersoek. ŉ Verdere doel is om te bepaal hoe hierdie studente graag geassesseer wil word oor hul sorgsame gedrag in ŉ kurrikulum waar hierdie kenmerk nie pertinent geleer word nie. Watson se sorgsaamheidsfaktore en teoretiese raamwerk oor sorgsaamheid, sal gebruik word om die onderwerp na te vors. Bloom se Taksonomie van die affektiewe leergebied sal gesamentlik met Watson gebruik word as teoretiese grondslag vir die navorsing. Die studie-ontwerp is kwalitatief en verkennend. ŉ Doelbewuste seleksie is gedoen om spesifieke eerstejaar verpleegkunde studente (n=64) en vierdejaar verpleegkunde studente (n=41) by die navorsing te betrek. Die geselekteerde studente (n=105) van sewe (7) private opleidingshospitale in die Wes-Kaap, het aan nege (9) fokusgroep onderhoude deelgeneem (n=10-15). Die data-analise is deur middel van ŉ raamwerk-analise benader en ŉ deduktiewe strategie is gebruik. Die resultate van hierdie navorsing word omvattend bespreek en sal gebruik word ten doel voorgraadse verpleegkunde kurrikula in Suid-Afrika te informeer rakende die sorgsaamheidsprofiel van verpleegkunde studente. Aanbevelings, volgens die affektiewe leergebied, word ook gemaak oor hoe sorgsame gedrag geïnternaliseer kan word.

Tables

Key concepts

Assessment: To establish the level of a student's clinical and/or theoretical performance(s) according to previously established educational objectives and goals.

Assessment in the affective domain of learning: A dimension of learning that implies taking on external phenomena and the conversion thereof into internal perspectives, expressed as states of attitudes, interests, values, emotions and appreciations (Anderson, *et al.*, 2000).

Caring: There is no universal definition of caring, but there are universal ideas and principles (Leininger, 2012). Caring refers to: a specific context; interpersonal processes; nursing practice expertise; intimate relationships; sensitivity between individuals; and an openness and need for caring by the recipient. The caregiver's (nurse) moral foundations and professional maturity precede the act of caring, in an environment conducive to healing. As a consequence of caring, patients' physical wellbeing can be enhanced, while nurses' and patients' mental health can be improved (Finfgeld-Connett, 2008).

Caritas Nursing: (*Caritas (Latin) – something fragile and precious, which must be sustained*). Caring is a transpersonal act, executed with humanity, compassion and love, within a therapeutic nurse-patient relationship, which results in a relationship of caring and healing (Dinapoli *et al.,* 2010).

Caritas Processes: The essence of nursing and the core of the profession, as determined by Watson's Caring Theory, are made up by these 10 essential Caritas Processes (Dinapoli *et al.*, 2010).

Internalisation: The most complex level of the affective learning domain. The clinical aspect of being a caring nurse is internalised by nursing students when they make professional values their own (Mogodi *et al.,* 2003).

Nursing:

> *"Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles" (ICN, 2014).*

Professional values: Favourable professional standards of action. Behaviours can be assessed according to this framework (Parvan *et al.,* 2012).

Table of Contents

Chapter 1: Introduction and context

This chapter will show the reasoning why the study was undertaken in the specific context. A concise literature review about the background of the problem and the theoretical underpinnings for this study will introduce the reader to the rest of the study. The research question, aims, methodology and ethical considerations are briefly presented. The possible impact and limitations of the study are also acknowledged.

1.1. Background

Appropriate professional values and behaviour ought to be emphasized in the learning outcomes of health professions education to ensure competent health professionals (Brown, 2011; Danielsen and Cawley, 2007). Unfortunately the wide use of the concept of professionalism, referring to the wise application of sound communication skills, clinical competence and legal and ethical understandings, caused disintegration of its meaning (Danielsen and Cawley, 2007). In the nursing profession, one of the core values of professionalism is care (South African Nursing Council, 2013), yet there is a growing body of evidence which implies that the caring roles of nurses need further inquiry (Brink, 1990; Jali, 2012). Jali (2012) specifically refers to public dissatisfaction about the lack of enthusiasm and caring attitudes in nurses. Because caring is central to nursing (Ousey and Johnson, 2006), it is the norm that most nurses would claim that they are caring. It is therefore important for nursing students to do regular reflection on their perceptions of caring behaviours (Ranheim, Kärner and Berterö, 2012), in order to determine whether internalization of these behaviours is taking place during the training programmes. Not much is said in current literature about the internalization of caring behaviours in nursing curricula (Brown, 2011), and it was the similar finding of the researcher for this current study, when analysing the current nursing programmes' curricula.

The South African Nursing Council (SANC) has announced that nursing programmes, which are currently offered by nursing education institutions (NEI's) in South Africa, are phasing out by 2015. In response to this, NEI's are challenged to design curricula, according to new qualifications frameworks, which will not only ensure the new categories of nurses will receive appropriate training, but will also be fit to function in a complex and ever changing health care environment (Griffiths, Speed, Horne and Keeley, 2012). These nursing graduates should be equipped not only with the necessary knowledge and skills, but also with the needed professional values and attitudes, like caring behaviours (SANC, 2013). This study focused on nursing education and the perceptions of first- and fourth-year nursing students working in seven (7) hospitals in the Western Cape, South Africa, of their own caring behaviours and how they would like to be assessed about it.

1.2. Theoretical frameworks

Both Jean Watson's caring model (Dinapoli, Nelson, Turkel and Watson, 2010) and Bloom's taxonomy of learning in the affective domain can provide the theoretical framework to integrate caring into nursing curricula (Cook and Cullen, 2003). In 1979 ten carative (caring) factors were identified by Jean Watson as the essence of nursing which should guide the practice of nursing. In 2008 these carative factors were redefined as caritas processes by Jean Watson, defining the caring nurse as someone who cares for the patient behind the diagnosis and procedures, behind the behaviour which the nurse might dislike or not approve of (Dinapoli *et al.,* 2010). Watson's theory asserted that healing is potentiated if the 10 caritas processes are demonstrated by the carer. Table 1 illustrates these processes.

Bloom's taxonomy of learning refers to three domains of learning, identified by Bloom in 1956, as: i) cognitive or knowledge; ii) psychomotor or physical skills; iii) affective or attitudinal (Anderson, Krathwohl, Airasian, Cruikshank, Mayer, Pintrich, Raths and Wittrock, 2000). The model of affective domain (Andersen *et al*., 2000) outlines Bloom's taxonomy of affective competencies as guidance for the development of values, like caring behaviours.

Table 1: Watson's Final Ten-item Caritas Processes (Dinapoli, *et al.*, 2010)

Nr	Caritas factor	Statement / criteria
1.	Caring with loving kindness	Care is always provided with loving kindness.
2.	Making decisions	Health care teamwork to solve problems, also for individual patient needs and requests, is evident.
3.	Instillation of hope and faith	Honouring of patient's own faith, instilling hope and respect patient's belief system.
4.	Teaching and learning	Health education is taught in an understandable way on the patient's level of understanding.
5.	Acknowledgment of spirituality: beliefs and practices	Encourage patient to practice own spiritual beliefs. It is acknowledged as part of the self-caring and healing process.
6.	Caring is holistic	Patient as a whole is cared for with responses on the individual needs of the patient.
7.	Creating a relationship of help and trust	A relationship of help and trust is created and maintained during nursing care interactions.
8.	Creation of an environment to enhance healing	An environment conducive of healing for body, mind and spirit was created and maintained.
9.	Promotion of expression of feelings	Promote opportunity for patient to openly and honestly about his/her feelings.
10.	Miracles	Accepts and support the patient's and family's beliefs regarding higher powers.

1.3. Relevance

Perceptions of caring behaviours of first- and fourth-year nursing students from various private hospitals, after different time periods during their training programmes, has not been the topic of many research studies in the health care profession. Furthermore, previous work done in this context is limited. For example students who participated in a study where the perceptions of students of their caring behaviours was explored, were from only one institution (Nadelson, 2010). Mindful of this, because of the importance of the aspect of care for nursing education and the health care, the aim of this study is to further explore the perceptions of nursing students from seven different private hospitals.

1.4. Strengths

In trying to measure caring attitudes, a complex, subjective, invisible human phenomenon must be reduced to an objective level. This can have a diluted effect on the authenticity of the experience (Watson, 2009). However, the literature does stipulate that it is possible to develop measurement of care through qualitative standards (Watson, 2009). A strength of this study is that, although the students were from seven different hospitals, a relatively small sample (105 students) from only one training institution could be used to describe their understandings and experiences of this complex phenomenon. It was the expectation of the researcher that this qualitative study would respond to the needs of the stakeholders (hospitals) and the profession. Therefore findings will be used to inform the curricula developers about the perceptions of nursing students as they progress through the nursing programmes as well as their views on assessment of caring behaviours.

1.5. Problem statement

According to the literature reviewed, there seems to be confusion within the nursing profession about what student nurses say about caring and what they actually do as caring. Therefore the perceptions of first- and fourth-year nursing students of caring behaviours need to be explored.

1.5.1. Rationale

The rationale of this study is to explore and compare first- and fourth-year nursing students' understanding of caring behaviours.

1.5.2. Research questions

- How do first- and fourth-year nursing students perceive caring behaviours?
- How would the students like to be assessed about their caring behaviours?

1.5.3. Aim of the study

The purpose of this study is to explore and compare first- and fourth-year student nurses' understanding of caring behaviours and to find out how they would like to be assessed about their caring behaviours. The identified caring behaviours will be grouped according to the 10 Caritas Processes of Watson's caring theory (2008). Blooms Taxonomy of affective learning outcomes (in Anderson's *et al.*, 2000) was consulted to see whether there were changes in behaviour from earlier years of studies to later years of studies. Consequently, the intension is to inform the undergraduate nursing curricula developers about the development of affective learning, like caring behaviours, in nursing students.

1.5.4. Objective

- The objective of this study is to examine the self-perceptions about caring behaviour in student nurses. The study will also explore how student nurses would like to be assessed on their caring behaviours.

1.6. Research methodology

The mode of enquiry will be qualitative.

1.6.1. Research design

The design of the study is qualitative and explorative. The qualitative and explorative designs take into account the student nurses' understandings of caring behaviour. Their behaviours are still elusive and therefore needs more description (Klopper, H., 2008; Maree and Van Der Westhuizen, 2009).

1.6.2. Study population

The study population comprises of all the nursing students in their first-year and fourth-year of formal nursing programmes from seven (7) private hospitals in the Western Cape.

1.6.3. Sample size and sampling methods

To increase efficiency, non-probability purposive sampling, was used, because it was expected that the selected participants would generate useful data (Patton and Cochran, 2002).

1.6.4. Inclusion criteria

Nursing students who met the listed criteria and who were willing to reflect on their perceptions of the phenomenon were invited to participate in the study. (See page 5 for explanation of nursing curricula).

- First-year nursing students after six (6) months of training, (n=35);
  These students commenced during January 2014 with the first year of a four year programme (Regulation 2175).
- First-year nursing students after eleven months of training, (n=29);

These students commenced during June 2013 with the first year of a four year programme (Regulation 2175).

- Fourth-year students after 23 months of training, (n=17);

    These students commenced during June 2012 with the first year of a two year bridging programme (R683 following on the first two year programme).

- Fourth-year students after 18 months of training, (n=24).

    These students commenced during January 2013 with the first year of a two year bridging programme (R683 following on the first two year programme).

First-year students refer to students doing a two year programme and final year students are students registered for a two year bridging programme which follows on the first two years. Table 2 explains the inclusive criteria.

Table 2: Study population

Programme	Duration of programme	Regulation	Year of training	Intake date (commencement of studies)
Enrolled nursing certificate	2 years	R2175	First	January
Enrolled nursing certificate	2 years	R2175	First	June
Bridging diploma programme to registration as a nurse	2 years	R683	Fourth	January
Bridging diploma programme to registration as a nurse	2 years	R683	Fourth	June

1.6.5. Data Collection Procedures

Focus group interviews was conducted, with samples of students (n=10 - 15), which comprised of students from each hospital, purposively selected according to age, race, gender, marital status and base hospital. The participants were requested to complete a survey to indicate the needed demographic details (Addendum A). Semi-structured focus group interviews were conducted in a relaxed and familiar setting by an independent interviewer. The interviews were recorded with the participants' consent.

1.6.6. Data management

Some practical aspects that were considered were confidentiality and security. For this research project, framework analysis was used with the justification that the researcher's intention was to group the emerging themes, from the students' perceptions, according to the existing Caritas Processes Framework themes (Table 1, on page 2); (Watson, 2008; Dinapoli *et al.*, 2010). Key demographic variables (Addendum A), which might have an impact on the perceptions of care of the participants, were grouped on a sampling grid in various variables combinations (Patton and Cochran, 2002). This was done to try to ensure that each interview group is represented by the different demographic backgrounds.

1.7. Ethical considerations

The researcher had to obtain written approval from the Health Research Ethics committee at Stellenbosch University, the researcher's institutional Research Approval Ethical Committee, the educational institution, and the participants. The participants were invited to take part in the focus group interview via a letter with an explanation of the purpose of the study and an accompanying informed consent form. The completed demographic data surveys were locked in a steel cabinet. Files with electronic analysed data were protected in a password protected computer. The researcher planned for incidences where participants might not cope with the outcomes of their perceptions of caring behaviours, for example should a student view him/herself as not being caring enough.

1.8. Anticipated impact of the project

By clarifying the nursing students' perceptions of care, the curricula can be informed of the findings for consideration to be included in the nursing programme curricula. It is the intention and responsibility of the researcher to distribute the findings as presentations during health education conferences and seminars. Upon successful completion of the study, the findings will also be submitted to the hospitals' ethical committees, the training institution's ethical committee and the participants.

1.9. Limitations

Three limitations that have to be acknowledged are that the knowledge generated in the Western Cape might not be generalisable to the other training institutions, the data collection and analysis can take more time than planned for, and subjectivity by the researcher and participants can influence the data.

1.10.   Summary

The concept of caring appears to be central to nursing, and as a consequence, the capability of a nursing student to be able to care, became a desired attribute of the graduating professional (Griffiths *et al.,* 2012*).* However, teaching, learning and assessment of caring values is currently a challenge for nurse educators (Brown, 2011). Therefore the desired outcome of this study is that it will reveal what student nurses perceive as caring behaviours and how they would like to be assessed about it. Whether there are internalisation of these behaviours and integration of caring into teaching and learning might also be determined from the responses.

1.11.　　Outline of the study

Chapter 1: In this chapter an overview was presented to set the foundation for the study.

Chapter 2: In this chapter the literature considers the perceptions and factors influencing perceptions of care and caring behaviours in nurses and student nurses.

Chapter 3: This chapter describes the research methodology used in this study.

Chapter 4: The data analysis is presented in this chapter.

Chapter 5: The results are discussed in this chapter and limitations of the study as well as contributions for future research studies are included. Recommendations and a summary of the research conclude the study.

Chapter 2: Literature review

2.1. Introduction

Teaching and assessment of professional attributes became the interest of health professions educators as part of their roles to address unprofessional behaviours (Danielsen and Cawley, 2007; Shaw and Degazon, 2008; South African Nursing Council, 2013). Danielsen and Cawley (2007) advised that different domains of professional competencies, such as cognitive, technical and affective, should be included in the curricula and assessed from the first training years of health professionals.

Many of the health professions share the responsibility to teach and assess professional behaviours and attitudes (in other words, caring behaviours) (Danielsen and Cawley, 2007; Parvan, Zamanzadeh and Hosseini, 2012). Caring behaviours, compassion and integrity have been identified by some authors as the main professional behaviours in medicine and should therefore be included in the assessment of affective learning outcomes (Danielsen and Cawley, 2007; Donald, 2002). Ranheim, Kärner and Berterö (2012:2) assumed that certain questions are fundamental to all caring professionals and should therefore be the basis of regular discussions, throughout their professional careers; for instance, conversations about "what is suffering and well-being" and "what is caring". This same authors refer to Dahlberg and Segesten (2010) in order to make it clear that the philosophical and ontological nature of caring makes it difficult to define concepts of caring. This necessitates that the questions foundational to nursing and caring, such as "why nurses care" and "what makes nurses care", must be reflected upon in order to assist in defining the concepts. This study will focus on nursing education and the perceptions of first- and fourth year nursing students of caring behaviour.

2.2. Perceptions of caring by students during different years of training

Khademian and Vizeshfar (2008) found that nursing students who were in earlier years of training did not have different perceptions of caring from students in later years of training. A contrasting study, done by Eklund-Myrskog (2000), where nursing students were interviewed when the programme commenced and upon completion of training revealed that the students developed deeper understandings of caring behaviours over the training years. This again is different to Watson, Deary and Hoogbruin (2001) as well as Mlinar (2010) who found that nursing students lose some of their caring idealism in the later years of the programme due to the influences of the technical and professional aspects of caring. Murphy, Jones, Edwards, James and Mayer (2009) and Mlinar (2010) highlighted the perceptions of younger first-year students with no previous experiences in formal patient caring behaviours.

This level of students stereotypically agreed with the caring behaviours items used in Murphy *et al.*'s study. This study concludes with a discussion regarding the first-year students' beliefs and values about what caring behaviours in nursing involves, how nurses should act and perform, and what the expectations of the patients are. The first-year students' perceptions were mainly guided by principles of what is the right thing to do. In contrast, the third-year students' scores were lower for some aspects of caring, specifically speaking with a soft voice, remaining cheerful, and watching the patient closely (Mlinar, 2010).

The key findings in another study (Murphy *et al.*, 2009), which aimed to determine whether the perceptions of caring behaviours of nursing students change over three years, showed a significant difference in statistical means. Between the first-year and third-year students, the third-year students scored the lowest in the pre-/post-test when making use of caring inventory checklists. According to this study it appears that the educational process over the three years caused a reduction in caring behaviours (Murphy *et al.*, 2009). This revelation was similar to the findings in a study by Gray and Smith (2008) and Mlinar (2010) who argue that the change in caring behaviours is not always positive. Students became disillusioned, focused on getting the work done, and cynical when they got to the third year of studies. Consequently, in some situations, some nurses stopped being caring.

Watson (1979) (in Dinapoli, Nelson, Turkel and Watson, 2010) is of the opinion that the high technical component in modern nursing is responsible for the impersonal nature of caring. The point that the author emphasises is that an effective nurse-patient relationship cannot be nurtured without the human element in the clinical environment. Mlinar (2010) refers to a suggestion by Watson *et al.* (2001) that, in order to develop caring behaviours, student nurses should be exposed to different disciplines or wards in order to become familiar with various hospital climates. The reason for this is that the perception of caring differs from a medical ward to a surgical ward, where the latter can perhaps contribute to a more technical and professional perception of caring.

2.3. Profile of a caring nurse

Ousey and Johnson (2007) refer to the perceptions held by the general public about nursing and caring. They report that the nurse is the person who: i) holds patients' hands; ii) provides in patients' physical needs; and iii) talks to patients. In addition, Ramos (1992) describes the attributes required to have an effective nurse-patient relationship as: i) to be 'present' (in word, thought and deeds); ii) to be close; iii) to have professional bonding; and iv) to have an emotional connection.

However, since 1980s some authors in Ousey and Johnson (2007) reiterated that, according to service users' responses in surveys, physical presence is not all that caring are about. It is also to understand patients' verbal and non-verbal communication.

In a qualitative study that was done about the key qualities that service users look for in nurses (Griffiths, Speed, Horne and Keeley, 2012), it was revealed that it is important that they have knowledge and willingness to learn and to find out. But the overwhelming priority identified was to have a caring professional attitude. Further analysis in Griffiths *et al.* (2012) revealed the major attributes sought after is communication skills, empathetic patient care; and non-judgmental patient-centred care. An over-all concern from the participants was whether the student nurses will be educationally prepared to develop the caring attitudes during their training programmes (Griffiths *et al.*, 2012). In order to be able to measure care, there should be consensus about the concept of caring and the role of caring in nursing. Caring is often referred to as care, which is physical, external or a task, while other views are opposed to any meaning of care as a duty or obligation. The meaning of caring in nursing literature is explained as (Ranheim *et al.,* 2012):

•   caring as a human trait;

•   caring as moral imperative, e.g. a value or virtue;

•   caring as affect toward patient, oneself or one's job;

•   caring as interpersonal interaction and therapeutic intervention.

Ranheim *et al.* (2012) refers to three (3) empirical studies that revealed some of the caring intentions and reflections on caring as a lived experience by nurses. Across the three studies the following concepts emerged: i) caring in distress; ii) gaining meaningfulness; ii) sense-making; iii) becoming aware; and iv) being present in person. Although various opposing viewpoints about the place and meaning of caring in nursing science exist, caring as a core concept for nursing science to develop is increasingly agreed upon (Watson, 2009). Various theorists support caring as the foundation of nursing and as a meta-paradigm concept that builds nursing and caring theories (Watson, 2008; Dahlberg and Segesten, 2010).

Rytterström, Cedersund, and Arman (2009) posit that any caring culture should view the deeper meaning of the phenomenon of caring as vital. Since the interpretation of this meaning and the deep understanding of it enrich the caring culture, for nursing this will imply how nurses will care and perform caring with efficacy (Ranheim, 2011). Research in the caring field showed confusion between what nurses *said about caring* and what nurses actually *do as caring*.

Patient and nursing encounters have been extensively referred to as caring, within the discipline of nursing (Watson, 1979, 2008; Benner and Wrubel, 1989; Leininger, 1993; Swanson, 2005; Eriksson and Lindström, 2009; Dahlberg and Segesten, 2010). There nursing is more referred to as the work of a nurse. Dahlberg and Segesten (2010) emphasise that the caring aspect of nursing stretches beyond the work of a nurse, which furthermore encompasses the question of what the meaning of caring really is. Pearcey (2010) argued that it would be possible for a nurse to do the work of nursing *without being caring*, based on the findings of an exploratory study done where student nurses implied that communication and caring is less than what their expectations was, and that nurses are not as caring as they aspire to be. A significant concern expressed was that nurses are not expected to do the little things anymore; like taking time to listen, talking, and holding hands.

Although there is a considerable amount of qualitative research on nurses' perceptions of what caring is, the concept is still not fully understood and remains elusive (Ranheim *et al*., 2012; Sargent, 2012; Khademian and Vizeshfar, 2008, 2007; Finfgeld-Connett, 2008; Brilowski and Wendler, 2005). The profession of nursing was epitomised by Florence Nightingale's perspective of nursing being caring. In her Notes on Nursing in 1859 (Nightingale, 1859, in Benck, Dugan, Hicks, Keller, Nuzzo, Drake, Wharton, Pysar, Bartle, and Ockerbloom, 1859 n.d.), amongst other positive factors, she insists that healing processes must be enhanced by the healing powers of nature. In 1859 Florence Nightingale postulated that ideal temperature, fresh air, hygienic conditions, light and sound (at reasonable levels) in addition to existential and social needs are positive aspects for a patient's recovery and well-being (Nightingale, 1859 in Benck *et al*., n.d.). It would seem as if one can summarise caring behaviours as embracing situations in specific contexts with qualities of openness, responsiveness and authenticity (Watson 1979, 2008; Nortvedt, 2003).

The inter-relational dynamics between the nurse (the caring person) and a patient (the human being) forms part of the foundational definition of caring. The openness and needs of the person to receive the care and the personal maturity, moralistic foundations and professional maturity of the carer will determine the proceeding of caring. Attitude, capacity, ability and characteristics are also attempts to describe caring (Finfgeld-Connett, 2008). The shaping of the human being as holistic with body, spirit and soul is part of the caring nurse-patient relationship and involves the true needs of the patient. Additionally, empathetic and attentive presence was recognised by Bamfo and Hagin (2011) as sealing holistic caring.

11

The definition found in literature which resonated best with the researcher was that patients felt like people who mattered, based on the caring nurse-patient relationship (Bamfo and Hagin, 2011) and when they are cared for with a loving heart (Watson, 2008).

2.4. Theoretical underpinnings

The science of and dialogue about caring theories has evolved and grown, since 1979 until 2008, from research and academics to the practical environment (Watson's caring theory in Dinapoli *et al.*, 2010). In 1956 already, the three learning domains of educational activities were identified as: cognitive (mental skills or knowledge); affective (growing in areas of feelings and emotions or attitudes) and psychomotor (physical or manual skills) (Anderson, Krathwohl, Airasian, Cruikshank, Mayer, Pintrich, Raths and Wittrock, 2000). Both Watson's model of caring (Dinapoli *et al.*, 2010) and Bloom's taxonomy of learning in the *affective* domain provide a theoretical framework that can be utilised to integrate caring into nursing curricula (Cook and Cullen, 2003). The model of affective domain (Anderson *et al.,* 2000) outlines Bloom's taxonomy of affective competencies as guidance for the development of values, like caring behaviours. Nurses often see theory as abstract, difficult to transform into the execution of their activities (Ranheim *et al.,* 2012). In 1979 ten Carative Factors were identified by Jean Watson as the essence of nursing, which could guide the practice of nursing, through which transpersonal caring (human to human) is characterised with interrelated characteristics. Watson (2008) explains Carative Factors as interactions between the nurse and the patient, which is nurturing, with personal commitment. The core of nursing and effective nursing practice is represented by these Carative Factors. These factors also aid in the understanding of nursing practice and education by providing order, structure and language (Wade and Kasper, 2006).

Grounded in the humanistic value system (Ranheim *et al.*, 2012) these Carative Factors made the difference between nursing practices focused on tasks versus a professional nursing practice. In 2008 these Carative Factors were redefined as Caritas Processes, defining the caring nurse as someone who cares for the patient behind the diagnosis and procedures, behind the behaviour of which the nurse might not approve or dislike (Dinapoli *et al.*, 2010). Table 1 (page 2) illustrates these Caritas Processes. Caring constitutes the integration of complex qualities that Watson's Theory refers to as Caritas (Ranheim *et al.*, 2012). These qualities include the practicing of love and kindness; has to do with interactions where the caring person goes beyond him/herself; and being supportive of the patient's negative and positive feelings while being genuinely present in the patient-nurse caring encountering.

Caritas also refers to having a caring consciousness and existential dimensions are allowed while the caring person experiences a fulfilment during the assistance of basic human needs of the patient (Ranheim *et al*., 2012). Watson's (2008) stance is that caring does not only look at the person like he/she is now, but what that person may become. And this makes the differentiation between a *caring* professional (caritas nurse) and a professional who is only interested in the medical *curing* side of patient care. Mlinar (2010) advised nursing educators to assist students to differentiate between the perception of caring and that of nursing, and furthermore to facilitate teaching and learning activities that will clarify behaviours of caring. That is why principles and rules of conduct are necessary to guide nursing students, and why nursing students must develop sound academic knowledge and caring behaviours. When nurses are challenged with making decisions and sorting of patient data effectively, it will be done in a way that will improve quality of patient care (Alligood and Tomey, 2010). More clarity, supported by Watson's theory on caring processes, resulted in the 10 aspects of care and caring (see Table 1, page 2) (Dinapoli *et al*., 2010).

Caring is identified as an interpersonal process characterised by interpersonal sensitivity, intimate relationships and nursing practice expertise, in accordance with Watsons' 10 Caritas Processes (Dinapoli *et al.,* 2010). The process of caring is context-specific, determined by the need and openness of the receiver for care, an environment conducive to caring and preceded by the nurse's moral foundations and professional maturity (Finfgeld-Connett, 2008). *Caring for* is described as when the nurse expresses nursing and *taking care of* is the operational tasks performed by the nurse (Dinapoli *et al*., 2010).

2.5. Learning caring behaviours

The importance of learning caring behaviours in nursing education was emphasised in the outcomes of a study by Ma, Li, Liang, Bai and Song (2014). They highlighted the effect the behaviours have on nursing students and patients. Ma *et al*. (2014) suggested that a patient's ability to cope effectively is hugely dependent on a sensitive and supportive caring nurse. This association was first described by Duffy in Ma *et al*. (2014) and the consequences for the human being cared for (patient or student) enhanced feelings of wellbeing (professionally in the instance of nursing students and personally in the instance of patients and students). Mental wellbeing was also reported to occur in the study by Ma *et al*. (2014) as a result of caring behaviours towards patients and students. These authors concluded that when experiencing caring, patients reported: i) improved relationships with others; ii) enhanced recovery and healing; and iii) spiritual and emotional wellbeing (Watson, 2008; Ma *et al.,* 2014).

An interesting fact was the reporting on the experiences of nurses who practiced caring behaviours. Their experiences were: i) professional and personal fulfilment and satisfaction; ii) love for what they do (nursing); and iii) living a personal philosophy (Watson, 2008; Ma *et al.*, 2014). Bamfo and Hagin (2011) furthermore elaborate on this nurse-patient relationship as being harmonious and meaningful.

The South African Nursing Council (SANC) has a Code of Ethics as the foundation of the nursing profession's values and professional behaviour. Of the five (5) core values, caring is the value considered most important. It should be applied and observed by nurses in their interactions with users of healthcare (patients and their families), educators, administrators, and other members of the multiprofessional team. Caring, according to this core value, entails the application of positive emotions and professional competencies to the benefit of the nurse and the patient. Through this application inner harmony should be created within the healthcare profession (SANC, 2013). However, dissatisfaction with services provided in health care facilities is often expressed by the public and media with particular emphasis on nurses' lack of enthusiasm and caring attitudes (Jali, 2012; Mogodi, Jooste and Botes, 2003). Jali (2012) is of the opinion that, in order to ensure that nursing graduates value the moral and ethical values of the profession (Nurses' Pledge of Service), teaching and assessing caring attitudes should be part of nursing education.

A review of the nursing programmes' objectives for the undergraduate nursing programmes in South Africa (SA) was conducted as part of the background to this study and it revealed non-specific caring behaviour outcomes. On the contrary, the physical care learning outcomes, referring to patient care activities — for example wound care, administration of medication, — are generally well described and have well designed criteria to find nurses competent in these learning outcomes. Brink (1990) states that non-specific programme objectives that relate to caring must maintain the ethical codes of the profession and must encourage nurses to be sympathetic and empathetic during patient care interactions. For example, students must be able to show respect for the uniqueness and dignity of man. However, it is not clear how and whether these outcomes are taught and assessed in many of the undergraduate nursing curricula. Although the ethical foundations of nursing form part of most programmes' objectives, the teaching and assessment of ethics and values, like caring behaviours, are not explicitly included (Brink, 1990). Karao¨z (2005) elaborated on the ethical commitments in a nurse-patient relationship. The main underlying principles and issues highlighted are: i) the protection of human rights and dignity; ii) alleviation of patients' helplessness; iii) consent; iv) societal rights; and v) personal integrity.

In Swanson's theory of caring (1991), nurses are requested to: i) avoid making assumptions; ii) do value clarifications; and iii) request assistance and support as needed during the execution of caring roles. Like Watson's Theory (2008) the caring processes identified by Swanson is also applicable to the scientific nursing process. Swanson identified that caring processes are: i) striving to identify an individual's meaning of life; ii) availability to a person; iii) assisting those who cannot do it for themselves; iv) enabling, and v) encouraging faith (Swanson, 1991).

In a study by Ma *et al*. (2014), students expressed their learning needs with regards to caring behaviours. It was suggested by the researchers that formal nursing curricula should emphasise the art, knowledge, science, skills and attitudes of caring during formal nursing education programmes. Posner (1992) and Bender, Daniels, Lazarus, Naude and Sattar (2006) refer to a curriculum as both explicit (the modules and written set of intended learning outcomes) and implicit (the norms, roles, values and attitudes which lie behind the written learning outcomes). Critical thinking, role modelling, reflective practices, and environments conducive to learning (Cf. Watson, 2008 and Finfgeld-Connett, 2008) are hidden curricula learning outcomes that play a vital role in the development of caring attitudes in nursing students (Ma *et al.,* 2014). Nursing education institutions should therefore take note of these recommendations.

2.6. Internalisation of caring behaviours

A study done by Mogodi *et al*. (2003) focused on the facilitation of caring behaviour amongst nursing students in the North West Province of South Africa. Their study revealed that student nurses and educators at this institution seemed to know what the caring values were as well as which teaching strategies can be used to facilitate the values. The problem was the internalisation of the caring values. The values were only realised on paper, preventing the students to develop into caring professional nurses. The authors debated whether the reasons for this might be: i) that nurse educators are not role models of caring values themselves; ii) a lack of enough attention to values reflected in the curriculum; and/or iii) a lack of assessment of caring values. Mogodi *et al*. (2003) furthermore suggested that teaching strategies for value clarification should be introduced early in training years in order to facilitate caring behaviours. It seems that for student nurses to be able to internalise caring behaviours they should have to know what caring behaviour is and get feedback on their caring behaviour through various assessment strategies. Brink (1990) is of the opinion that student nurses will only understand the person who needs care when they understand themselves as caring persons.

Mogodi *et al*. therefore echoed that caring needs to be addressed continuously during training of nursing students to enhance the internalisation of this professional value. Karao¨z (2005: 8) mentioned that the responsibility to develop and internalise professional values, like caring behaviours, belongs to nurses, nursing students and nursing educators. The author clearly refers to this process as "to take in" beliefs, norms, skills, attitudes, ethical standards, knowledge and "make them a part of their own self-image and behaviour". The author emphasises the role of nurses and nursing educators to, not only ensure that student nurses are exposed to experiences that can assist in the development of the described behaviours, but that they should act as role models and by this means have an influence on their professional and ethical development. According to Bloom's Taxonomy of Learning (1956 in Anderson *et al*. 2000) the internalised behaviour is also consistent, predictable and pervasive. The taxonomy further postulates that internalisation can also be demonstrated when students: i) show self-reliance during independent functioning; ii) display teamwork; iii) utilise effective problem solving techniques; iv) display professional commitment and ethical behaviour on a consistent basis; v) revise judgments and change behaviour accordingly; and vi) value human beings for whom and what they are and not how they look (Anderson *et al*., 2000).

However, the assessment of specific caring behaviours is not part of the nursing curricula in SA. Here the nursing profession is challenged to deliver graduates who are equipped with the appropriate caring behaviours to care for patients in a complex healthcare environment (Jali, 2012; Parvan *et al*., 2012; Dinapoli *et al*., 2010; Mogodi *et al*., 2009; Shaw and Degazon, 2008; Weis and Schank, 2009, 1998; Brink, 1990). In the hospital context it is evident from patient satisfaction surveys, conducted during hospital stay, that patients regard a caring nurse-patient relationship as vital for positive health outcomes and for the total wellbeing of the patient.

2.7. Assessment of caring behaviours

Suggestions are made that nurses should rather be observed to measure the caring aspect than being assessed. It is also recommended that caring behaviours of nurses can best be observed by means of qualitative approaches through, for example, the experiences of the care receiver (Liu, Mok and Wong, 2006). Authors in caring literature do agree that the concepts care and caring are not the same (Brink, 1990; Weiss and Schank, 2009; Paley, 2001; Cook and Cullen, 2003; Brilowski and Wendler, 2005; Mogodi *et al*., 2009; Sargent, 2011; Ranheim *et al.,* 2012). According to Finfgeld-Connett (2008) and Dinapoli *et al*., (2010) the enhancement of mental and physical wellbeing for the patient and the nurse will be the result of caring behaviours demonstrated by nurses during patient interactions.

It does seem as if all agree that human caring comprises of knowing (cognitive domain), doing (psychomotor domain) and being (affective domain), since this can be found in strong theoretical frameworks such as Bloom's Taxonomy (Anderson *et al.*, 2000; Dinapoli *et al.*, 2010; Liu *et al.*, 2005). Some authors describe *care* (in opposition to *caring*, which is in the affective domain) as being the cognitive and psychomotor domains of competence (Brink, 1990; Paley, 2001; Brilowski and Wendler, 2005; Danielsen and Cawley, 2007; Ranheim *et al.*, 2012).

A common factor of caring identified by theorists is the caring-healing relationship between patient and nurse. Caring is emphasised and valued as a sacred act. Empirical evidence of caring interactions by student nurses may assist educators and curriculum developers to assess caring behaviours during nursing care interactions. Chinn and Kramer (2008) assert that this knowledge is the easiest to relate to and therefore the most practiced form of knowledge. Other forms of knowledge include ethical, personal and aesthetical knowledge, of which aesthetical and ethical are not clearly reflected in practice. Currently it seems as the only measuring instruments for the purpose of measuring caring behaviours in nurses are derived from Watson (2008), *Caring assessment tool to measure nurses' caring activities in terms of the Carative Factors* (now known as the Caritas Processes) and the *Caring Factor Survey for nurses* (Dinapoli *et al.*, 2010; Persky, Nelson, Watson and Bent, 2008). This latter survey measures caring when practice is guided by Watson's caring theory.

However, the assumption is that when students or nurses are assessed by means of these instruments, they already have a clear understanding of the caring processes (as described in Table 1, page 2) (Nelson, 2013). Assessment of professional values, such as caring behaviours in nursing students during different stages of their training, is important to develop future empowered nurses. Therefore, students have to understand what these caring values mean and the development of it must be part of the nursing curricula (Parvan *et* al., 2012). This will furthermore develop students in the affective domain (Miller, 2005; Anderson *et al.*, 2000). For example, when an injection must be administered to a patient, the nurse's cognitive, psychomotor and affective abilities all interact. The nurse's cognitive abilities are reflected in deciding on the length of the needle and calculating the dosage. His/her psychomotor abilities rely on the injection being administered in a competent, safe manner. This could be an acceptable experience for the patient if the affective competency is also present. In the affective domain, the student assumes responsibility for the intervention and the injection is administered in a caring way that is not traumatic for the patient (Brown, 2011).

This interplay of the three domains of learning illustrates that the internalisation and characterisation of caring behaviours will only be demonstrated when students display professional commitment by changing their behaviour; in other words, caring attitudes according to the levels of the affective domain of Bloom's Taxonomy (Miller, 2005).

Although the focus of this research is not assessment of caring behaviours, it is important to assess whether internalisation of caring behaviours is taking place from the first to final years of training. Internalisation is the most complex level of the affective domain of learning (Anderson *et al.,* 2000; Cook and Cullen, 2003). Therefore, students should show progression in the development during their years of training, starting from the less complex processes first, which are receiving (showing awareness) and responding to the phenomena (of caring behaviour). Then progress is made to the internalisation and characterisation processes of valuing the caring behaviour and organising the changed behaviour into a value system (Anderson, *et al.*, 2000).

2.8. Conclusion

The cultivation of a caring culture in healthcare systems and nursing education is exceedingly important, according to extensive discussions of the meaning of caring behaviours (Mlinar, 2010; Ousey and Johnson, 2007; Griffith *et al.*, 2011). Educational strategies to improve these behaviours and students' perceptions of these aspects are not well presented in the literature (Ma *et al.*, 2014).

Having reviewed ample literature on the aspect of care, and in order to explore the possibility of capturing caring attitudes during nursing care interventions, the next step was to understand more about the perceptions of nursing students. The researcher wanted to determine nursing students' perceptions of caring behaviour during different levels of their training in seven (7) hospitals in the Western Cape. The intention was to determine whether internalisation (the highest level of value development in the affective domain of learning) of the caring behaviours took place as the students advanced to the senior levels.

Chapter 3:   Methodology

3.1. Research question

The questions: *How do first- and fourth-year nursing students perceive caring behaviour?* and *How would students like to be assessed on their caring behaviours?* were investigated by means of exploring the perceptions of caring behaviours of these students.

3.2. Study objectives

The study objectives were to examine the self-perceptions about caring behaviour in student nurses.

3.3. Research design

In order to give other researchers enough information to replicate this study, this chapter will be devoted to clearly define and describe the qualitative research design process. The chapter will show how the parts of the project came together in an attempt to answer the research question. The purpose of this study was to explore and compare first- and fourth-year student nurses' understandings of what caring behaviours consist of through a qualitative and exploratory design. The intent was furthermore to explore the profile of a caring nurse, as perceived by the student nurses, according to the Caritas Framework of Watson's Caring Theory (Persky, Nelson, Watson, Bent, 2008; Dinapoli, Nelson, Turkel and Watson, 2010). In this framework, love and caring are acknowledged as the central aspects in a humanistic patient-nurse healthcare context. The value of establishing such a profile is to inform undergraduate nursing curricula, in order to assist in the development of professional behaviours and values, specifically caring behaviours, in undergraduate nursing students.

After the exploration, the identified caring behaviours were grouped according to the 10 Caritas Processes of Watson's Caring Theory (2008). According to the model of Bloom's Taxonomy of learning domains, (Anderson, Krathwohl, Airasian, Cruikshank, Mayer, Pintrich, Raths and Wittrock, 2000), the development of values is categorised in the affective domain of learning. Both Bloom's Taxonomy and Watson's Caring Theory can facilitate the integration of caring behaviours into the teaching and learning of professional development in nursing curricula (Cook and Cullen, 2003).

3.3.1. Qualitative research design

The study will not explore how much and how many (statistics), which quantitative measures can do more effectively.

The researcher wants to explore the attitudes, perceptions, meaning and understandings of nursing students about the how, why and what of caring behaviours as experienced in everyday life situations. For this aim, the qualitative method is more appropriate (Brikci and Green, 2007 and Whitehead, 2007). Bulpitt and Martin (2010) and Bamfo and Hagin (2011) confirm that this research method is effective to obtain information from a specific population about opinions, values and behaviours. Polit and Beck (2010) and Sandolowski (2000) differentiate between quantitative and qualitative research, the latter being more holistic and in-depth to produce rich data as the basis of the research work. Furthermore, the research method utilised, systematically explored meaning through empirical inquiry (Shank, 2004). Systematically refers to ordered, following agreed upon rules, planned and public, while empirical refers to experiences.

3.3.2. Exploratory research design

Student nurses' perceptions of caring behaviours in private hospitals in the Western Cape have not yet been reported. Therefore the exploratory research was embarked upon (Botma, Greef, Mulaudzi and Wright, 2010) with the conceptual framework of Watson's Caring Theory in mind (Persky *et al.*, 2008). This latter theory and framework guided the researcher towards the decision to have a deductive strategy, in managing the data collection and data analysis, conceptualising and operationalising through a logical process (Botma *et al.*, 2010; Ritchie and Lewis, 2008). The plan was to explore how the first- and fourth year nursing students' perceptions of caring behaviours compare with Watson's framework, but the researcher had to remain open for emerging themes and concepts that could build onto and add to the existing knowledge (Ritchie and Lewis, 2008) of the perceptions of caring behaviours. Ritchie and Lewis (2008) also mention that comparison in qualitative data can be very effective in understanding phenomena. For this reason, the researcher also compared the perceptions of first- and fourth year students with each other.

3.4. Instrumentation

Two instruments were developed to collect the data for the research study, namely the demographical data survey document and the focus group interview prompts. The researcher created authentic instruments. In line with Brink, Van der Walt and Van Rensburg (2012), a pilot study was conducted with students (n=11) who met the inclusive criteria. These students did not form part of the sample and the data collected and was thus not included in the main research study. The rationale of doing the pilot study was to identify potential weaknesses in the study methodology (Brink *et al.*, 2012). The researcher found no flaws in the methodology during the pilot study.

3.5. Setting and participants

The target population (Brink *et al.*, 2012) was 105 nursing students in their first- and fourth-year of formal nursing programmes from seven (7) private hospitals in the Western Cape. The focus group interviews were conducted at the campus during scheduled theoretical blocks. The researcher obtained written permission from the class lecturers to schedule the 45 minute focus group interviews with the students for certain dates and timeslots, in order to cause as little disruption as possible.

3.5.1. Study population and sampling

The aim of the study was not statistical representativeness.   Therefore the purposive sampling method, implying that the focus group participants were selected because of the likeliness that they will produce useful data, seemed most appropriate (Parahoo, 2006; Brikci and Green, 2007).   Botma *et al.* (2010) advise on two guiding principles for qualitative sampling to ensure a holistic and rich understanding of the phenomenon being studied: i) the sample who participated in the study need to be *appropriate*, meaning that the selected participants can produce useful data about student nurses' perceptions of caring behaviour; ii) the sample is *adequate* – in other words, producing enough data to describe the perceptions of care.

The decision with regards to the number and characteristics of participants for this study were informed by suggestions made by Polit and Beck (2010) and by Botma *et al.* (2010). Polit and Beck (2010) state that qualitative research samples can be small and selected according to information needed. Botma *et al.* (2010) advise that data must be collected in the context where the participants experience the matter being studied. Various authors in Brink *et al.* (2012) added that sample size is adequate when the topic is fully explored and there is clarity on meanings (data saturation).   This implies that no new information is produced by the focus group interviews.

The criteria for the population sample were clearly defined to ensure the participants meet the inclusion criteria.   Relevant to the topic under investigation, undergraduate nursing students who met the listed criteria (see Table 2, on page 5) and who was willing to reflect on their perceptions of caring behaviours were invited to participate in the study (Botma *et al.,* 2012).   Participants in the study were registered students for the four years of training, which consist of two separate qualifications (Regulation 2175, first year, and Regulation 683, fourth year, of the South African Nursing Council - SANC).   Students have a break of six (6) months or more between the R2175 and R683 programmes, which is a requirement of the SANC. Each programme is two years.

Therefore the students in the second year of the R683 programme are referred to as the fourth-year students in this study. The training institution accommodates two intakes of each programme per academic year: January and June.   The reason for selecting these participants was because the 41 fourth-year students had more practical experience and theoretical knowledge than the 64 first-year students, and the researcher's intention was to explore and compare perceptions of earlier years and later years of studies. Table 2 (page 5) illustrates the study population.

A sample of the following groups was invited to take part based on specific inclusion criteria:
- First-year nursing students after six (6) months of training, (n=35);
  These students commenced during January 2014 with the first year of a four year programme (Regulation 2175).
- First-year nursing students after eleven months of training, (n=29);
  These students commenced during June 2013 with the first year of a four year programme (Regulation 2175).
- Fourth-year students after 23 months of training, (n=17);
  These students commenced during June 2012 with the first year of a two year bridging programme (R683 following on the first two year programme).
- Fourth-year students after 18 months of training, (n=24).
  These students commenced during January 2013 with the first year of a two year bridging programme (R683 following on the first two year programme).

The student demographic data for the interviews was obtained from the training institution's student management information system and statistical database, after the necessary consent was obtained from the institution's management. In order for the researcher to have an accurate database of the participants per focus group, the participants also completed a demographic survey prior to the focus group interviews.   Maximum variation sampling method (see Table 3 on page 23), which is a purposive strategy of sampling to create heterogenic groups, was used. The aim of this method is to explore the phenomenon from people with differences in demographic backgrounds (Cohen and Crabtree, 2006; Smith and Cilliers, 2006). Key demographic variables guided the selection of the participants for the focus group interviews, with the understanding that these variables could probably have an impact on the sharing of opinions about caring behaviours. A sample grid was created to assist the researcher in the selection of the various group combinations (Brikci and Green, 2007). The demographic variables included: i) age, ii) race, iii) gender, iv) marital status, v) year of training, and vii) base hospital.

Table 3: Interview schedules with heterogenic groups

Date	Year of training	Number of participants	Maximum variation sample combination included
21/05/14	1st year after six (6) months of training,	(n=12);	Female, Male, White, Black, Coloured, Single, Married, Ages: 19-40
21/05/14	1st year after six (6) months of training,	(n=11);	Female, Male, Black, Coloured, Single, Married, Ages: 20-43
21/05/14	1st year after six (6) months of training,	(n=12);	Female, Male, Black, Coloured, Single, Married, Ages: 19-41
09/07/14	1st year after 11 months of training,	(n=14);	Female, Male, Black, Coloured, Asian, Single, Married, Ages: 20-45
09/07/14	1st year after 11 months of training,	(n=13);	Female, Male, Black, Coloured, Single, Married, Ages: 22-50
09/07/14	1st year after 11 months of training,	(n=2);	Female, Black, Single, Ages: 22, 25
13/05/14	4th year after 23 months of training	(n=8)	Female, Male, White, Black, Coloured, Single, Married, Ages: 24-49
13/05/14	4th year after 23 months of training	(n=9)	Female, Male, Black, Coloured, Single, Married, Ages: 26-38
10/07/14	4th year after 18 months of training	(n=12).	Female, Male, White, Black, Coloured, Single, Married, Ages: 23-46
10/07/14	4th year after 18 months of training	(n=12).	Female, Male, Black, Coloured, Single, Married, Ages: 23-41

3.6. Data Collection Procedures

Focus group interviews were conducted, with samples of students between 10 and 15, with the exception of one first-year focus group that only had 2 participants.

23

The reason for the small group was due to peers who decided not to participate anymore, for no specific reason. According to Smith and Cilliers (2006) opportunities to participate during focus group interviews and the management of the interview by the interviewer can be influenced by the size of the group. In this study it seems as if the group sizes were adequate since students participated actively.

The focus group interviews were conducted at the training institution and an independent interviewer held the interviews. The interviewer was able to engage in a relaxed and familiar setting with the respondents (Kruger, 2002; Denscombe, 2010) with minimal disturbances. Circle seating was arranged in order to create an open environment to stimulate group interaction. Some practical aspects that were considered were confidentiality and security (emotional and physical) of the participants and the independent interviewer. After welcoming the respondents, a short introduction was made, because the students were familiar with each other but not with the researcher. A general discussion was then allowed between the group and facilitator prior to the commencement of the interviews in order for the interviewer to get to know a little more about the participants (Griffith, Speed, Horne and Keeley, 2012). Thereafter the researcher proceeded to give a quick overview of the session and explained some ground rules for the interview session. The first discussion point was raised as soon as the researcher was satisfied with the environmental arrangements and no uncertainties indicated by participants.

The interview was based on two (2) questions. The first question was: "*In your opinion, what do you believe are caring behaviours and what actions or behaviours might nurses demonstrate as caring?*". The interviewer gave the participants one minute to reflect before the group had the opportunity to respond to the question. The second question was: "*How would you like to be assessed about caring?*". The participants were encouraged to narrate about their perceptions of care with minimal need for probing questions. Yet the following probing questions were prepared and asked during some of the interviews when probing (Ritchie and Lewis, 2008) was required:

> "*How do you know that you are a caring nurse?*"
> "*Please tell me a bit more about this.*"
> "*Is there anything else you would like to add to this?*"

Probing questions are asked by an interviewer as a response to what the participants have already raised and may be asked should more detail or clarity to understand the response be needed. Ritchie and Lewis (2008) regard probing as an essential interviewing technique and clearly distinguish probing from prompting and asking leading questions.

The latter two techniques will generate data initiated by the interviewer and not by the participant (Ritchie and Lewis, 2008). This was an important factor for the outcome of this present study, because the students had to give their own perceptions, without being informed about the Carative Framework, so that authentic data about caring behaviours could be generated without being guided by the carative factors.

The conclusion consisted of a summary and confirmation of the main points of discussion. It was important for the interviewer to review the purpose of the interview with the participants, after which all respondents were thanked and dismissed. Each interview, which lasted about 45 minutes, was tape-recorded after participants gave informed consent. Minimal disturbances were experienced. The semi-structured focus group interviews facilitated a process where data could be collected from more participants at the same time. Another advantage of this form of group interview is the potential interaction between participants during data generation. Because the researcher wanted to explore perceptions and experiences of care, this method was chosen (Kitzinger, 1995; Denscombe, 2010).

3.7. Role of the interviewer

The interviewer was independent and a staff member from another higher education training institution, unfamiliar with the participants and context of the research. The researcher orientated the interviewer to the environment and interview questions during a meeting prior to the interviews. No training was needed as the interviewer was experienced and trained to conduct focus group interviews. As part of her daily activities, she facilitates qualitative interviewing skills with postgraduate students during their contact sessions at the higher education institution where she is employed. The interviewer was not informed of the theoretical framework (the Caritas Factors) that was going to be used in the data analysis, therefore all responses from the students about caring behaviours were pure and provided without any guidance (Ritchie and Lewis, 2008) about the Caritas Factors.

3.8. Role of the researcher

The capacity of the researcher at the training institution, as the head of campus, requires close involvement with students and their academic experiences at the campus. Therefore the researcher was not involved with the data collection during the focus group interviews or the transcribing of the data from the recordings. The latter was also done by an independent person. However, the researcher was directly involved with obtaining the informed consent from the participants, receiving the completed demographic surveys and analysing the data from the transcriptions.

3.9. Data management

The researcher wanted to maintain the balance between being concise, yet preserving data richness, especially with large quantities of data obtained during open ended questioning in focus group interviews (Polit and Beck, 2010). Each verbatim quote was read and coded before it was categorised according to the Caritas Factors. The challenges of qualitative research include the analysis of sometimes huge amounts of data and the reduction of this data in order to compile the research report (Polit and Beck, 2008; Bamfo and Hagin, 2011). Furthermore, the research material and data obtained during recording and transcribing of interviews was managed in an ethically approved manner (described in Ethical Considerations, section 3.9). The texts from the interviews were typed into a word processing document for analysis.

3.9.1. Analytic approach

For this research project, framework analysis approach was used. The researcher's intention was to group the emerging themes, from the students' perceptions, according to the existing Caritas Framework themes (Table 1 on page 2; Watson, 2008; Dinapoli *et al.*, 2010). In order to become familiar with the data (Silverman, 2011), the researcher read the transcribed data several times line by line to identify meaningful segments, which were then coded. This process continued until all the transcribed data have been segmented, coded, summarised and categorised. The researcher looked for patterns, associations and explanations in both the first- and fourth-year students' perceptions in order to develop explanatory accounts (Silverman, 2011). Themes that emerged could then be grouped on the Caritas Factors framework, which were also labelled with existing numbers 1-10 as the ten Caritas Factors.

3.10.   Rigour

This study incorporated measures to ensure rigour (Brink *et al.,* 2012), reliability and validity as follows:

- a pilot study was done prior to the study to test the methodology
- because objectivism during research methodology is regarded as a form of respect for the participants under study, the focus group interviewer was an independent person who did not know the students and vice versa (Ratner, 2002)
- the interviewer was a skilled interviewer who conducted the focus group interviews in a consistent manner by only asking the designed interview questions and probing questions

- the interviewer was made aware of her own possible preconceptions and bias related to the topic by attending a pre-focus group meeting with the researcher to discuss any issues which might arise during data collection

- only the proposed interview guide was utilised for the focus group interviews

- the same interviewer conducted all the interviews

- interviews were transcribed verbatim by an independent person

- the interview transcripts were checked for accuracy by listening to the voice recording

- the researcher was made aware of own possible preconceptions and bias related to the topic prior to the data analysis process through introspection and reflection

- personal communication enriched the researcher's own perceptions (Ranheim, 2014; Nelson, 2013)

- the data was coded manually by the researcher after it was read several times and all responses were appropriately coded

- the verbatim responses were grouped according to an existing thematic framework and, since this needed some researcher interpretation, a peer co-checked the codings and groupings.

3.11.   Ethical considerations

The researcher obtained written approval from the Health Research Ethics committee at Stellenbosch University, the researcher's institutional Research Approval Ethical Committee, the educational institution and the participants. The participants were invited to take part in the focus group interview via a letter with an explanation of the purpose of the study and an accompanying informed consent form. Informed consent was obtained voluntarily, after a verbal explanation of the proposed study, by the researcher. Informed consent was signed by participants and the researcher; each safeguarded a copy. The necessary written permission was obtained to use a certain venue at the training institution to conduct focus group interviews.

Participants were assured of anonymity, confidentiality and the reassurance that decisions to not take part, or to withdraw at any stage, will not be held against them. In terms of confidentiality, the identity of all participants and information gathered were protected at all times. Respondents were informed that the semi-structured focus group interviews would be conducted by an independent interviewer and that responses would be recorded. A person who was not affiliated with the training institution received the recordings, immediately after the interviews, for transcription. The completed demographic data surveys were locked in a steel cabinet.

Files with electronic analysed data were protected in a password protected computer. Protection of the participants' emotional safety was a big priority for the researcher. The researcher planned for incidences where participants might not cope with the outcomes of their perspectives of caring behaviours, for example, should a student view him/herself as not being caring enough.   Discussion sessions about their feelings or workshops on caring behaviours would be facilitated after the interviews as needed. Additionally, the institution has a service available, which is free of charge for all registered students, an Independent Counselling and Advisory Service (ICAS), which can assist in these situations.

3.12.   Summary

This contextual study explored the perceptions of caring behaviours of 105 first- and fourth year nursing students, with a qualitative and exploratory design. The aim was to explore and compare these perceptions in nursing students during different years of undergraduate nursing programmes. A deductive strategy was used, guided by the underpinning theoretical frameworks of Watson's Caring Theory and Bloom's Taxonomy of learning in the affective domain.

Data was collected by conducting nine (9) semi-structured focus group interviews, during which opening questions and probing questions were asked by the interviewer. Interviews were recorded, transcribed and prepared for framework data after the researcher manually coded the transcriptions.   Throughout the study qualitative reliability and validity were evaluated. The researcher documented demographic data accurately and transcripts were checked and compared with information on recordings for accuracy (Botma *et al.*, 2012). The thematic groupings, according to the Caritas Framework, were checked by a peer.

Chapter 4: Results

The researcher focused on the existing Caritas Factors themes (Persky, Nelson, Watson, Bent, 2008; Dinapoli, Nelson, Turkel and Watson, 2010). In 2008, these carative factors were redefined as Caritas Processes, defining the caring nurse as someone who cares for the patient behind the diagnosis and procedures, behind the behaviour of which the nurse might not approve or dislike (Dinapoli *et al.*, 2010). Table 1 (on page 2) illustrates these processes. Major themes emerging from the responses of the first-year nursing students after six (6) months of training and eleven months of training, respectively, were grouped according to the Caritas Factors with verbatim quotes from the students in order to provide the perceptions of the students at these levels of training to the reader. The same process was followed for the fourth-year students after 18 months and 23 months of training, respectively.

4.1. Caring behaviours: perceptions of first- and fourth-year nursing students

The first-year students, both after six (6) months and 11 months of training, mostly expressed their perceptions of caring behaviours, and whether they are perceived as being caring by others, by means of everyday experiences or incidences. Incidents used to illustrate their caring behaviours were often referred to in context of family, community and friends. Nine (9) of the ten (10) Caritas Factors emerged from the responses, which lead the researcher to the assumption that the majority of the first-year students sample can be classified as being caring nurses. This is illustrated in Table 4 below by the responses and applicable verbatim quotes. Additional themes also emerged from the analysis of the focus group interviews, which will be described as part of this chapter. The researcher found that the majority of verbatim responses from the first-year students after six (6) months and 11 months of training correlated. Therefore the results of these two groups were combined as: First-Year Students: perceptions of caring behaviours.

Regarding the perceptions of the fourth-year students, there were many that referred to all ten (10) Caritas Factors, which may be a positive indicator that they are caring when nursing the patients. These verbatim responses are illustrated on the Caritas Framework (Table 4). Additional themes emerged from the students' responses as well, which will be presented in this chapter. As with the case of the first-year students, it was found that the responses of the students after 18 and 23 months of training were similar enough that it could be combined as: Fourth-Year Students: perceptions of caring behaviours.

4.2. Themes and categories

The ten (10) Caritas Factors of caring, labelled in Table 4, are measured per factor by various verbatim statements of first-year students' perceptions of caring behaviour and fourth-year students' perceptions of caring behaviours.

Table 4: Watson's Final Ten-Item Caring Factors (Dinapoli et al., 2010): Caritas Factors compared to 1st and 4th year students' perception quotes.

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
1.	Caring with loving kindness	Care is always provided with loving kindness.	Most of the students indicated that love is perceived as a positive emotion. *"…to show emotion when you take care of patients".* *"Caring is when you have love and you show love."* Other positive emotions verbalised, together with love, are warmness, compassion, patience, passion and considerations for the patient's feelings. Compassion with the patients and conducting interactions to try to cheer up patients and making them smile were identified by these students as caring behaviours. *"To love what you are doing is caring and to treat your patient as you would treat your family"* and *"…If you do not have the love, you will not care…"*	These students were less passionate about the loving kindness than the first-years. *"I would say I would care for someone that's not able to care, that's not able to help themselves. So I will try to do things for that person".* *"…caring is to see the need in a person that this person, maybe she needs something that I can help with. So I just help that person. "* *"Caring, when you care for a person, you have to have the passion for it."* *"You must treat a patient with a caring heart. You must feel like that patient is your mother or your father...caring for me is about love and dignity and friendliness."*

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
			"Care starts with love for yourself, because then you know how it feels to care about somebody else, thinking about somebody else's feelings."	*"You do what the patient doesn't even expect of you."* *"Principles of Batho Pele. Trust and openness…I must love the patient… feel the pain…feel what they are going through…if I have love. I can smile… even difficult situation..."* *"…but actually taking your own time to fill somebody else's field of time, spending time with them…not physical contact, but just spending time with somebody means that you have taken the selflessness from the world and everyday society."* *"Caring for me is you show that person you are concerned about his whole situation and you show sympathy for where that person finds him or herself in that stage of his or her life. Also just to show love, that shows you care."* *"Patients in surgical wards are very anxious and scared, I will hold their hands and encourage them."*
2.	Making decisions	Health care teamwork to solve problems, also for individual patient needs and requests, is evident.	A few students referred to "*making a difference*" and *"trying to improve someone's situation*" by involving other members of the healthcare team, as a caring factor.	The fourth-year students reflected much more than the first years on the importance of directing patients to other members of the health care team as a caring behaviour.

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
			"If I do something about a problem for the patient, I care"	*"…I will advise the person to the next level then, because that is also caring… direct them to channels which can offer them assistance…e.g. a mental problem that the patient or the person has and the family can't cope with it, get a psychiatrist or social workers to come and see them and speak with them."* Discussion also revealed that patient rights must be respected, which the researcher linked to decision making (by the patient). *"Respecting the rights of the patients"* *"Privacy and confidentiality"* *"Their right to refuse treatments"* *"…giving them the option so that they can make choices as well…informed consent… communication"*
3.	Instillation of hope and faith	Honouring of patient's own faith, instilling hope and respecting patient's belief system.	The aspects of consideration and respect for patients' belief systems and for the patient as a human being, as a caring behaviour, were mentioned. *"A caring nurse for me is someone who respects a person as a human being, and will try to do good for the next person without like being rewarded with worldly goods."*	Conversations emerged that caring for a person goes along with respect for a person *"because you can't care for a person if you don't have respect for that person."* *"…caring behaviour has to do with respect, because you won't be able to care for someone if you don't respect that person… and also to be able to show empathy……relate to the patient or to the person about the situation…"*

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
4.	Teaching and learning	Health education is taught in an understandable way on the patient's level of understanding.	Communication skills and making sure the patient understands what is happening on the patient's level of understanding was mentioned as important. No specific reference was made to health education, rather communication in general *"…to communicate on the level of the patient in a language the patient understands… no medical jargon…"*	In comparison, views on education to the community and effective communication, as a strategy to illustrate caring behaviours, were shared. *"The way you communicate with other people, going down to their level of understanding, because if they don't understand what you are talking about, then it's like you don't care…"* *"…it's part of education, especially in this level of education that we are at now. It's all about your attitude out there, the people, even the students, at that level, the community outside also…you need to communicate to people in a language that they understand, and care for them holistically."*
5.	Acknowledgment of spirituality: beliefs and practices	Encourage patient to practice own spiritual beliefs; it is acknowledged as part of the self-caring and healing process.	Respect for traditions and culture and to know a patient's background was perceived as a caring behaviour.	*"You have to respect differences like religious differences, and culture"* was a response in agreement with the first-years' perception. *"Not physically always doing something to the situation, but just being there and actually listening."* *"…respect for patient's rights…"*
6.	Caring is holistic	Patient is cared for as a whole with responses to the patient's individual	For some of the first-year students, The admission form checklist is sufficient to address the aspect of holistic care.	Caring behaviours during care for the patient as a whole was strongly supported and in-depth.

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
		needs.	*"The hospital admission form will assist you to consider your patient holistically."* Some students mentioned that the caring nurse will "*show the person that you are concerned about his whole situation."* *"Caring is to look at a patient holistically…"* was well represented in the responses, but no elaboration was provided on this. *"To care for the patient's needs in a practical way by providing in the basic needs (food, clothes and social)."* *"Caring means to take care of the patient emotionally, physically and spiritually."*	*"…caring,…being there for the person, physically and emotionally, being able to listen to the person, being able to open up…."* *"Caring is your capacity to understand the needs of the other person."* *"Be fully present for that patient so that you can listen to them and be there emotionally, physically."* *"…you see the nails are long and dirty, 'let me cut your nails for you, let me do your hair for you, or how was the food? Did you have food, or did you have enough food, or do you want something else?'"*
7.	Creating a relationship of help and trust	A relationship of help and trust is created and maintained during nursing care interactions.	Help and trust appeared to be one of the major perceptions of being a caring nurse for most of the students on this level. *"When you care for somebody else the way you would care for your family."* *"Caring is to provide care in a certain way."*	The professional development after three years of training became evident in the responses made related to patient advocacy. *"Caring for a person is going beyond the limits. You would go to the utmost furthest to do something for the person, especially if the person can't help themselves."*

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
			Going the extra mile for patients and wanting to do more for the patients were very common perceptions of caring behaviours and examples included: *"When a patient looks depressed / lonely / in need of attention, to ask the patient if there is anything he or she needs or wants you to do"* *"…it can be greeting someone in his/her own language, assisting someone to get directions (in the community), physical care or just listening…"*	*"…it's all about respect, but at the same time you have to build a relationship with that person, understand the needs of the patient and compromising as well…"* *"…he didn't need me to be holding his hand or anything like that. He needed me to alleviate his pain. He was educated to what I was doing, and just knowing what was going on, and sort of reassured in the way that it will be better, then he was more relaxed and he could also just accept what is going on."* *"…patient didn't complain to the doctor about the pain or vomiting, because he was not comfortable to speak to the doctor, but you came because you showed you care…"* *"Talk to them and analyse their fears, or explain to them what happened, and maybe offering them tea or coffee."*
8.	Creating an environment to enhance healing	An environment conducive to healing the body, mind and spirit is created and maintained.	**This aspect was not covered in the students' perceptions of caring behaviours.**	Perceptions of caring behaviours were strongly related to the rights and environment of the patient and how it enhances healing.

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
				"If I care, I will create a therapeutic environment…this causes healing…if patient gets better I can say I created a therapeutic environment…I will give myself credit for that…I must be the eyes and the ears, the body of that patient…some patients need all those needs, and you can see and hear everything of that patient…do everything for that patient…" *"…we have to put ourselves in that patient, or that person's body…"* Patients' rights were mentioned frequently and included discussions of patient safety: privacy, confidentiality, option to make choices, informed consent for all interventions and communication.
9.	Promoting expression of feelings	Promote opportunity for patient to talk openly and honestly about his/her feelings.	The aspect of "*caring is being there for the patient*" and "*caring is careful listening*" was elaborated upon extensively by students in this group: *"…be there in an assisting manner…to listen carefully with your whole being, without being judgemental, is a caring behaviour."* To be open towards the patient and not only to provide opportunities for openness by the patient, were identified as a caring behaviours:	Listening and really being there for the patient was not as strongly described as by the first-year students. *"Communication is a very big thing if it comes to caring because without communication, you will never know how that patient is"* *"…reassure them they are fine and … we are here for you if you need to talk or anything…"*

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
			"…show your interest and let the patient feel he/she is more important than me." *"When patients see that I am interested in them and I want to help them, they open up to me..."* *"…to stay in control of my own emotions and to stay calm with difficult patients…"*	*"…touching their hand, showing that you are there for them, you are here to support them…"* *"…it would be knowing the person you are caring for and knowing which method of caring is suited for that specific individual…* *"…maybe a certain conversation or just understanding in what situation that person is in might be seen as a caring behaviour."* *"I also think it's the way you approach the patient, because some patients feel they can't talk to you. You don't introduce yourself… so then the patients have a fear to talk to you about their needs."*
10.	Miracles	Accepts and supports the patient's and family's beliefs regarding higher powers.	A Muslim student shared the incidence of having to encourage a Christian patient and to talk about God with this patient in order to encourage the patient: *"…making her feel fine and comfortable and that she is in good hands, that is what I feel I showed her…we became very close…she feels like my grandmother…"*	*"Caring knows no, caring has no boundaries. If you choose to care for that person, you are not looking at their race, you are not looking at their capabilities, you are not looking at their background, but you are caring because you want to help. You want to make that person feel better."* Not being judgemental about patients' beliefs in higher powers were shared between the two groups of students:

Nr	Caritas Factor	Statement / criteria	First-year students: perceptions of caring behaviour	Fourth-year students: perceptions of caring behaviours
			"Caring for me is not being judgemental. Also, caring for someone is valuing the person's opinions and ideas. I think that is what caring is."	*"Caring, for me, is not being judgemental. Also, caring for someone is valuing the person's opinions and ideas."*

The verbatim quotes in Table 4 are a representation of the perceptions of these student nurses. It was evident during the last few focus group interviews that no more new ideas or perceptions emerged anymore, indicating data saturation. The researcher remained open for themes emerging from perceptions that are additional to those grouped in Table 4, as illustrated in the next section of this chapter.

4.3. Additional themes from the first-year nursing students' perceptions of caring behaviours

<u>Humble approaches</u> during nursing care interactions were perceived as caring by male participants of the various first-year interview groups, with matched responses in this regards from male students in the fourth-year groups:

- *"…a humble approach to assist somebody to get better, or to feel better about themselves."*
- *"The way you interact with the patients, not showing your authority over them"*
- *"Caring is from the inside, not about money; you must be humble, caring come first then the money….nursing makes you humble...nursing totally takes you in a humble way, and sometimes you learn a lot of who you are… I never thought I will be this person…"*

Another theme that emerged was the student nurses' <u>internal drive</u> to be caring. The first-year students spoke very passionately about nursing as not about the money but about the love for what you want to do, which is quite in contrast with the fourth-years' perceptions of nursing as illustrated in 4.2.3:

- *"It is not to expect something back…caring starts when you are born, at home, with the family…"*
- *"…caring also entails your community, your workplace, your peers at the campus, by giving advice, talks and assist peers with studies."*
- *"You cannot teach someone how to care; either you are born with it or without it"*
- *"A better caring person is not a better nurse…"*

<u>Empathy</u> was quite a dominant factor emerging from the responses. Students generally felt that you cannot nurse a patient without empathy, because you will not understand what the patient is going through. An empathetic caring nurse's behaviour was described as:

- "*To do something about a patient's pain*"
- "*putting yourself in the shoes of the patient*"
- *"…you are definitely a caring person, when your empathy takes over in those situations where you would normally actually try and remove yourself…"* (These situations were referred to as handling bedpans, body fluids, etc.)

<u>Sympathy</u> was also quite prominent. Strong perceptions about sharing emotions with patients and not only attending to the needs were shared:

- *"…to feel the pain with the patient"*

Certain <u>attitudes</u> were mentioned as requirements to be a caring nurse:

- "*A willingness to care for others.*"
- "*To care willingly, with an open heart and committed*"
- "*…interested to learn more, shows you care… I am caring because I want to do what I am doing.*"

Students, who perceived <u>nursing and caring</u> as two different concepts, either made it very clear that caring and nursing are not the same or some perceived it as being part of the job.

- *"Caring for me will be just basically doing what you are supposed to do, and taking care of the sick, because ultimately this is what we are in for. This is the profession we choose, and by caring you will be doing your nursing; you will be doing good for other people. "*
- *"I feel that caring for a person is doing the job that you are doing, caring for the sick, caring for those who are not able to help themselves, treating people with respect as well, and having empathy for those that are suffering."*
- *The image of a nurse I held before I entered the profession was that a nurse is this sweet, sensitive, passionate, loving, peaceful person, changed drastically a few months after I entered the profession. Majority of nurses show anger and sadness, is miserable and morbid and does not match the image I had before…"* The same student also asked, "*Did nurses then became so strained from giving too much care, that they have no more care?*"

<u>Emotions and feelings</u> expressed as being associated with being a caring nurse were:

- *"…feeling appreciated…"* This was expressed by a few students and they indicated appreciation from patients and managers as important factors, especially if the appreciation is unexpected.
- *"…feeling of fullfilledness…to make others feel special and when I feel good about myself after I have cared for patients, makes me feel like a caring person……when I get emotional during my nursing care activities…when patients thank me for something I did, which I was not even aware of and it made a difference to them…"*

The majority of the students verbalised that when patients tell them that they are going to miss them or ask them when they will be back at work again are also indicators that they are perceived as being caring.

- *"…the patient said that she could see that I am a caring nurse and that I am different from others…"*

Some first-year students viewed <u>caring for the dying patient</u> as a caring factor on its own:

- *"…caring for a dying patient and making that patient as comfortable as possible…"*

4.4. Additional themes from the fourth-year nursing students' perceptions of caring behaviours

Some respondents perceived <u>nursing and caring</u> as two concepts:

- *"It's not always that you are caring when you attend to a patient's needs. You can attend because you have to. I would say if you are caring, you attend with everything in you. You are sympathetic towards the person, and you show empathy, and you share the emotions of that person, because sometimes you can just attend to a patient's needs because you don't want a bad report, you see. So, it must come from inside you."*

- *"I think sometimes it's difficult to determine if somebody really cares, because there are certain things that you do and you get so accustomed to it, or you do it so well, that it's like a trained behaviour. You do it because you know exactly how it's done, and for the next person that may be like you are caring, and in the meantime it's just you are doing your job very well, and it's got nothing to do with how you feel, you know, your feelings inside. You're doing it because you can."*

- *"There is a difference between nursing and caring. But I have seen people nursing, like with no smile on their face, just nursing that person and you can see the expression on the patient's face because there is no smile, you don't respond to the patient who is saying something. So, we've got two jobs, nursing and caring...it's not just about nursing doing the caring."*

- *"Nursing is like when I do what I have to do for the patient. I have to feed that patient, I have to, if they are incontinent, I have to change the nappy, I have to do that, but caring is totally different. Caring will be I will spend time with the patient, chat to the person, and give him a smile or even a hug if it's necessary."*

- *"Caring for me will be just basically doing what you are supposed to do, and taking care of the sick, because ultimately this is what we are in for. This is the profession we choose, and by caring you will be doing your nursing; you will be doing good for other people."*

- *"I feel that caring for a person is doing the job that you are doing, caring for the sick, caring for those who are not able to help themselves, treating people with respect as well, and having empathy for those that are suffering."*

- *"Caring is I am a nurse because you need to care all the time, so it depends on your attitude also, and your family background, where you come from. "*

43

- *"You get people who don't care, those are not necessarily people from bad backgrounds, but in our case in the nursing line, it takes a special person to be a nurse. Once you start studying, like when you start caring for someone, you will always be alert, and even if you are not in the nursing environment, you will care, having the example where someone is at college, not at work, but you still help them and care for them. So once you have it, it will always be there."*

- *"I think it comes down to the ability to care. That in itself is a verb, not a thing of wanting to do it, or being obliged to do it. It comes down to our essence and how compassionate we are in our ability to care. You know, it's not because we are supposed to do it."*

The characteristics mentioned by the fourth-years matched some of what was mentioned by the first-years:

- *"Caring is a lot of characteristics that you have to have. You have to be respectful, independent, friendly, and you have to go the extra mile for the patient."*

A humble approach during nursing care interactions was perceived as caring by male participants of the various fourth-year interview groups as well:

- *"Nursing makes you humble. Nursing totally takes you in a humble way, and sometimes you learn a lot of who you are, I never thought I will be this person …"*

Empathy and sympathy also featured in the fourth-year responses, with more elaboration than from the first-year students:

- *"To be able to understand or to give care, I need to understand or to at least have an idea of what this other person is feeling, what they might need, and wanting the best for the patient, they are someone, for example it's someone else's brother, it's someone else's mom, it could as well be my mom…"*

4.5. First-year students responses on how they would like to be assessed on caring behaviours

Very little responses were generated from the question: "*How would you like to be assessed on caring behaviours?*" The researcher is of meaning that this can be because the students are not used to be assessed on professional behaviours and values, like caring behaviours, as it is not part of the curriculum to assess students on these behaviours.

The following are examples of responses:

- *"…once you receive feedback… will indicate to you that you are caring..."*
- *"…I think when somebody acknowledges and thanks you for an action that you have performed; you know that you have actually had a caring attitude according to it…"*
- *"…caring is part of a basic human personality trait in a lot of people without you knowing it, and by just doing something basic for somebody, you know it must have been a caring related thing because they thank you for it…"*
- *"…those (the patients) are the judges. If you do not perform, they are the people who speak afterwards. Either it's a good thing or it's a bad thing coming from it. So you as a nurse should always be aware of your surroundings at all times, no matter what… make sure that you present yourself better to the patient…"*
- *"…Matron spoke to me once, and she told me that there are e-mails with your names in it. I asked her is it good or bad…the unit manager told me…all good emails that came, just from patients. I was shocked, because I never thought that these people that I don't even know from any side, they are sending in messages to say that this person did his work well…"*

4.6. Fourth year students' responses on how they would like to be assessed on caring behaviours

The fourth-year students responded as follows:

- *"If I want somebody else to judge me, I would be acting in a certain way; I would do something I do not mean, because I am being appraised for that…"*
- *"It would depend on the other person, who is judging me…"*
- *"…it might be fake…"*
- *"It might become a situation where you pretend to care because you are rated…"*

4.7. Summary

The wealth of perceptions of caring behaviours and experiences of first- and fourth-year nursing students, in this study, were grouped according to Watson's Caritas Factors and additional themes were also reported. The responses on assessment of these behaviours were surprisingly different from the first-years to the fourth-years' perceptions.

Chapter 5: Discussion

5.1. Introduction

This chapter discusses the findings of the study. Thereafter recommendations for further research, limitations of the study, general recommendations and a summary of the chapter will follow to conclude this chapter.

5.2. Discussion of the results

5.2.1 The profile of a caring nurse

Persky, Nelson, Watson and Bent's (2008) study on the profile of a caring nurse, found that there should be further academic inquiry into the profile of a caring nurse. The study reiterated that, in order for nurse educators to prepare future "Caritas Nurses" (discussed in Chapter 2), who will have the necessary competencies to nurse patients according to their unique needs, nurse educators must understand the characteristics of a caring nurse. The study furthermore hypothesised that such a nurse might have an impact on patient outcomes. Therefore, the results of this current study can inform the nursing curriculum about the profile of a caring nurse as perceived by students in early and later years of studies. From the data analysis, the profile of a caring nurse, as perceived by first- and fourth-year nursing students, could be compiled. The Caritas Processes Framework (Dinapoli, Nelson, Turkel and Watson, 2010) gave meaning to the narrated expressions of the participants' responses on the questions posed to them in the focus group interviews.

The implication of being "Caritas Nurses" was proposed by Watson's Caring Theory (Watson, 2008) in that a nurse with this profile can potentiate healing with love and caring behaviours. Watson's theory proposes that the development of caring relationships by a nurse is essential and the 10 Caritas Processes (Table 1) provide clear guidelines on this. Therefore the outcome of the present study is theoretically bound to Watson's Caring Theory (Dinapoli *et al.*, 2010).

It is important to be reminded that neither the participants nor the interviewer were aware that the responses will be grouped according to the Caring Framework with the 10 Caritas Processes (Table 1). A reason why the researcher did not inform the interviewer and participants was because of evidence from studies done by Mlinar (2010) and Murphy, Jones, Edwards, James and Mayer, (2009). They found that first-year nursing students tended to agree stereotypically with items listed as caring behaviours, even with no previous formal patient caring experiences, and were mainly steered by what should be the right thing to do. Hence the reason why no guidance of what caring behaviours should be, was given to the participants in the present study.

To follow is a discussion of the Caritas Processes as it emerged from the data. The first three factors, which comprise of the **value systems of both the nurse and the patient,** are interdependent and a reflection of the **individuals' value systems and humanistic caring abilities** (Watson, 1979, 2008). Therefore it will be discussed together.

5.2.2 Perceptions of caring behaviours according to the Caritas Factors 1, 3, and 6:

1.   Caring is with loving kindness (loving kindness during nursing care);

3.   Hope and faith are instilled (patient's own faith is honoured, instilling respect and hope; patient's belief system is respected) (Dinapoli, *et al*., 2010)

6.   Caring is holistic (patient is cared for as a whole with responses to the patient's individual needs.) (Dinapoli, *et al.,* 2010)

The philosophical belief, that practicing loving kindness during nursing interactions, is the most important experience for patients and their families. This is supported by an exploratory factor analysis that revealed a reliability of 0.89 in a study to determine whether a 10 item scale can measure caritas (Dinapoli *et al*., 2010). Dinapoli *et al*. (2010) refer to Watson in emphasising the importance of nurses having dialogues about caring with loving kindness. This practice, if coming from heart-centred awareness, will consequently grow and lead to improved patient outcomes.

In this study, the perceptions of the first-year nursing students of their caring behaviours indicated that caring with loving kindness is important to them. Congruent with the primary motivations of why students enter nursing as a profession, most first-year students elaborated on their love for people, themselves and the job they want to do. It is often shared by new applicants, during selection interviews for the respective nursing programmes at this training institution, that they enter the nursing profession for future financial security and because of their dreams to become a nursing specialist in one or other nursing field. However, the majority of students in this study expressed their genuine love and concern for other people, their families and patients, rather than to receive a financial reward.

- "…*observations from patients about my caring behaviour, that I am different from others (it is not about money for me)…*"

- "…*caring is from inside, not about money, you must be humble. You need the money, but caring is first…*"

- "…*some nurses do it for the money, and some do it for the love, the passion of nursing… I really wanted to be a nurse.*"

These findings are not surprising, as the first-year students in this training institution do not earn salaries, yet they opted to choose this institution as their training provider. Bamfo and Hagin (2011) had similar findings about the importance of nursing with loving kindness for students. In addition, Finfgeld-Connett (2008), described the students' declarations about love for themselves, their jobs and for other people.

It was evident during the first years' interviews that the references made to caring behaviours were not generally made to the clinical setting (referring to the hospital environment where they work as students), but rather to the personal setting (in their communities and at home).

- *"…in your community where you stay, you can see that people need help. If you are a caring person…"*
- *"…the way you will care for your children and your family, you must care for other people anybody else…"* (the interviewer asked the student to elaborate on "other people", to which the student responded *"anybody else"*).

These responses are congruent with the findings of Wilkes and Wallis (1998) that, upon entering the nursing profession, nurses bring their own attributes of caring with them and they relate these attributes to experiences with family, friends and communities.

More important caring behaviours mentioned by the first-year students, which indicated caring with loving kindness, included caring for the patient as a whole. Warmness, compassion, passion and consideration for others, were mentioned as caring behaviours.

- *"…you don't treat the patient's condition or disease; you treat the patient as a whole…"*
- *"…you must also have compassion…some patients, they open up a lot to you…they give you their whole life story just because of the way you present yourself. So if you are not going to pay attention to them, they are not going to consider you as a good help to them. They will seek the help of somebody else."*

These behaviours echo those found by Wilkes and Wallis (1998), who also studied the perspectives of nursing students about caring. In this study the students represented caring as nursing with compassion, providing comfort, communicating and also as being confident.

The fourth-year students expressed compassion in a more professional sense and made definite references to caring for different disciplines of patients.

This indicates changes in components of perceptions of caring behaviours that took place as the student progressed to the fourth year of studies:

- *"…when I'm working in surgical ward, like patients going to theatre, a lot of them are very anxious and scared. So for me as a caring person, I always encourage them with encouraging words, and you tell them don't worry, and just to keep their hand…"*

It was also Watson's belief that a perioperative nurse with compassion, care and therapeutic use of the self can, by intention, enhance healing in a surgical patient. Healing is enhanced by decreasing anxiety and stress in the patient (Norred, 2000). Students from both the junior and senior groups mentioned that they experienced love and care as positive emotions, which correlates with the postulations by the South African Nursing Council (SANC, 2013). The SANC's supposition is that holistic caring, as a core value of nursing, requires nurses to apply positive emotions and professional competencies to the benefit of both the patient and the nurse, leading to inner harmony (SANC, 2013).   This therapeutic patient-nurse relationship depends on the humanistic caring abilities between the nurse and the patient and is emphasised in Cossette, Cote, Pepin, Ricard, and D'Aoust (2006). However, the discovery of some first-year students that caring could also lead to feelings of disappointment, anxiety, negativity and being burdened is an important finding in this current study:

- *"…you give care and then they actually mistrust, or they disappoint you in your caring process…"*
- *"…is there such a thing as caring too much, because sometimes if you are somebody that always thinks about other people and you don't get yourself off the ground, it may impact you long term in depression and anxiety as you are always carrying a load..."*
- *…"I am new in this career, and I come as I am, but now I am also gaining more experience and I am also now getting baggage of my own, so I am in between being surprised, scared, at the same time I am still me…"*

The above statements were further explored by the interviewer and it was clear that there was no need to refer the students for further assistance to cope with these feelings:

- **Interviewer:** *"…you spoke about anger, you spoke about miserable, you spoke about a nurse's image that you perceive differently to what reality is…do you think that there is a balance, because you can become overburdened because of your caring, and in another aspect you can also distance yourself, but you can still care?"*

- **Students' responses**: *"…by changing one person's attitude, that could change the whole attitude around you, and I think that's what we are doing…it's easier now…it depends on the situation…"*

Next, the Caritas Factors that were identified as the **therapeutic** Caritas Factors (Watson 1979; Cossette *et al.,* 2006) are discussed.

5.2.3 Perceptions of caring behaviours according to the Caritas Factors 2, 7, 9 and 10:

2.   Decision making (solving problems as a health care team, caring for patient's individual needs and requests);

7.   Creating a relationship of help and trust (A relationship of help and trust is created and maintained during nursing care interactions);

9.   Promoting expression of feelings (Promote opportunity for patient to talk openly and honestly about his/her feelings);

10.   Miracles (Accepts and supports patient's and family's beliefs regarding higher powers) (Dinapoli *et al*., 2010).

Both the junior and senior groups mentioned that a patient's problems will be managed and/or that they will include other members of the health care team to manage the problems.

- **Fourth-year**: *"…I will advise the person to the next level then, because that is also caring… direct them to channels which can offer them assistance…e.g. a mental problem that the patient or the person has and the family can't cope with it, get a psychiatrist or social workers to come and see them and speak with them."*
- **First-year**: *…"If I do something about a problem for the patient, I care"*

Decision making and theory-based thinking processes during nursing actions, contribute towards the creativity of nursing practices and should, according to Dinapoli *et al*. (2010), be stimulated in the nursing profession. Therefore, although the fourth-year students did refer to respecting the rights of the patient and made some reference to the multiprofessional team, no elaborated clarifications of the importance of this problem solving- and decision making skills, regarding the processes and channels of communication to be followed to ensure the patient's problem gets resolved, is evident. This implies that the awareness of and the response to the patient's needs are caring behaviours in the students, but the internalisation process of this affective behaviour is not evident in the responses made by this sample of participants.

Students shared experiences where management of certain situations led to an enhanced feeling of wellbeing in patients:

- *"Go that extra mile for a patient. Say for instance they have a problem and ask(ing) you something, then you go and find out and you come back and tell them."*

- *"… the patient wants to be discharged, or they have pain, the medication doesn't work for them, for the pain, it's not effective, or the patient vomits…that minute I took the phone and called the doctor and explained to the doctor this is not working for the patient, can you try something else…because I care".*

According to Henderson, Van Eps, Pearson, James, Henderson and Osborne (2007) and Cossette *et al*. (2006), decision making requires the application of caring skills with openness, honesty and respect, and an appreciation for the individual patient's particular situation. The students from the respective groups shared the following, indicating that they do have the skills to create a caring nurse-patient relationship:

- *"…where you assist to improve somebody else's condition or situation that they find themselves in, but it's not always open that the person will actually accept you're caring."*

- *"Not everybody is open for caring on the receiving end."*

- *"…they can see or they can feel okay, this nurse is trying to help me. She is really interested in me, and then you see how the patients open up…"*

When the internalisation of these behaviours took place, a trusting, helping, caring relationship between the patient and the nurse can be sustained. However, the researcher realised that, in order to enhance and promote health and healing while fostering a patient's humanity and dignity, students need proper guidance by educators and mentors to accept this responsibility right from the first year of training. Parker (2007) commends nurses who equip themselves with necessary knowledge and skills to be able to make ethical decisions in a challenging environment and to support patients in making decisions. Caritas Factors 2, 7, 9 and 10 encompasses how nurses, who are knowledgeable with principles of ethical decision making, can become a valuable member of the multiprofessional team and can actually have an influence on the behaviours of others (Henderson *et al*., 2007; Cossette *et al*., 2006).

The clinical skills and ways that the nurse responds to the patient are the final discussion points. Watson (1979, Cossette *et al*., 2006) grouped the Caritas Factors applicable to the clinical skills and the nurse's responses to the patient's needs together as being **clinical care**.

5.2.4 Perceptions of caring behaviours according to the caritas factors 4, 5 and 8:

4.   Teaching and learning (Health education is taught in an understandable way on the patient's level of understanding);

5.   Acknowledgement of spirituality: beliefs and practices (Encourage patient to practice own spiritual beliefs; it is acknowledged as part of the self-caring and healing process);

8.   Creating of an environment to enhance healing (An environment conducive to healing the body, mind and spirit is created and maintained) (Dinapoli *et al.*, 2010).

Communication and understanding, relating to these three Caritas Factors, were the golden threads that ran through the responses from the nursing students during all of the focus group discussions. The first-year students verbalised caring behaviours related to these factors as caring through communication with others and being compassionate for the patient's situation. Yet, these students mostly illustrated examples of communication that they have encountered in their personal lives:

- *"…caring could be greeting somebody in their own language, caring could be assisting somebody who is looking for directions, caring could be doing something physically for somebody that they need, caring could be listening…"*

- *"…it's all about starting to love yourself, and you will know how it is to care about somebody else, thinking about other people's feelings, and also to ensure that you respect other people's traditions and know their backgrounds, and know how to talk to the people, and attitudes as well…"*

Offering comfort and being concerned about the patient and his/her needs were mentioned by the first-years, while the fourth-year students had more or less the same conversations about being concerned and having compassion. Nevertheless, the change in emphasis was evident when they elaborated about communication with the patient.

- **Fourth-years**: *"…with dignity (on the patient's level)…must make sure you and the patient understand each other…with a positive attitude…must decide whether there must be physical contact or not…I must listen with such attention that I will remember what was said, to be able to follow up on it…"*

In comparison, the comments first-years made about effective communication as being a caring behaviour, did not progress deeper than ensuring that the patient understands and that the nurse attempts to communicate in a language the patient understands.

Listening to the patients, however, was mentioned by the majority as an important factor. The current nursing curriculum does include communication learning outcomes, including verbal and non-verbal communication. This can perhaps explain the change in emphasis in the fourth-years' perceptions.

Another difference that became evident from the perceptions shared by the two groups of students was that the first-year students did not mention creating an environment conducive to healing as a caring behaviour, while the fourth-years had some views about this.

- *"If I care, I will create a therapeutic environment…this causes healing…"*
- *"Respecting the rights of the patients to enhance recovery…:"*

Healing can be the consequence of some key behaviours (Elvin, 2009). Therefore all students will have to become engaged with aspects of nursing that can assist in the professional development of those behaviours in a holistic manner. Key behaviours, which can promote healing and which match those of Elvin (2009), were mentioned by most students in both groups: i) **presence** *("put all your problems and worries aside and be fully present for that patient so that you can listen and be there emotionally, physically…")*; ii) **empathy** *("If you do not have empathy, you will not understand what the person is going through*"); iii) **verbal and non-verbal cues** *("…the way patients speak to me"* and *"when you see, e.g. a patient looks depressed / lonely / needs attention / needs motivation, to ask if there is anything the person needs or wants you to do"*.) Yet, the students did not relate these key behaviours to a conducive environment (bearing in mind again, the students were unaware of the Caritas Factors when the interviews were done).

Caring behaviour entails seeking a deeper level of being present with the patient. Watson (2008) refers to such a moment as *the caring moment* (Dinapoli *et al.*, 2010). This relationship should be sustained with *each patient-nurse interaction* and it is important for student nurses to know that there are barriers to presence, which they need to identify. Lack of time is a common barrier for nurses to having *caring moments* with patients. Preoccupation with other tasks, fear, impatience, distractions and not being open are further barriers that can exist (Elvin, 2009). In this study not much mention was made about barriers by students:

- *"…so I went to her and I closed the curtains, because I mean, there are other patients…, why can't that nurse see the patient is emotionally stressed, put it that way. I closed the curtains, she started crying."*

The above quote illustrates how a nurse created a caring moment by creating privacy for the patient and immediately the patient opened up to show her emotions. Secondly, as mentioned and conversed about by most students in both groups, to empathise with patients must never lose the real meaning. As reminded by Elvin (2009), it can easily become second nature for health care professionals to judge a patient's condition or experience, without focusing on the person (having *the caring moment*). Furthermore, it is not only the verbal but also the non-verbal cues of the patient that was mentioned as an important act of caring; as illustrated by a verbatim quote from a first-year student:

- *"…but she was the quiet type, she was just lying there, but you could see that something was not right. That bothered me for a whole day already, because I asked her if she wanted something to eat, she wants nothing, I asked her if she wanted something to drink, she wants nothing…"*

Ousey and Johnson (2007) mention the importance of being open to verbal and non-verbal cues.

5.3. Perceptions of assessment of caring behaviours

The sample of first-year students responded to the enquiry of how they would like to be assessed about their caring behaviours. They have never been assessed on caring behaviours as far as they were aware and, therefore, they interpret any type of feedback, which could be from the patient, the unit manager or the clinical facilitator, as an indication of whether they are caring. Examples of feedback mentioned by the students were verbal or written feedback from patients, hugs from patients, verbal appreciation and rewards (gifts). Furthermore, the students are aware of patient satisfaction surveys done in the hospitals where they work and they mentioned feedback received from their unit managers.

The fourth-year students were very cynical about being assessed on their caring behaviours. They also mentioned the feedback systems similar to those of the first-years, however, they have an overall perception that assessment of caring behaviours will result in *"being a fake nurse"*, *"putting up a show"*, and to *"pretend"*. As the assessment of caring behaviours is not yet part of the current undergraduate nursing curricula, some challenges lie in how the training institution and the clinical facility will ensure we are preparing graduates who will be genuinely caring and equipped to face the challenges of the health care environment.

5.4. The challenge to develop caring behaviour progressively from the first year to the fourth year

The learning of affective skills should lead to changes in behaviour, personal growth, and movement of loci of control (from external to internal).

Movement should also occur from receiving values to internalisation of values for nurses, as they progress in their studies. Affective competencies, like caring behaviours, should become a spontaneous and routine behaviour, illustrated during everyday nursing activities (Brown, 2011). Therefore, it was expected to find that fourth-year nursing students, after about three years of clinical experience, would go into far more in-depth discussions with ample examples from their own experiences of caring behaviours. Yet, as illustrated in the results found, most of their perceptions involved general responses that did not differ much from the first-year students' perceptions and experiences. This finding could be due to the absence of explicit affective learning outcomes in the curriculum. Brown (2011) refers to a study done by Murphy *et al.* in 2009, which revealed that third-year students' caring behaviours declined as they progressed through the years of training. Reasons debated for this erosion of caring behaviour included conceptualisation of nursing as a reality, which is opposite to the idealistic view of nursing during the first-year of training (Brown, 2011).

The perception of a first-year student during the focus group interview for the present study (edited), made this clear:

- *"The image of a nurse I held before I entered the profession was that a nurse is this sweet, sensitive, passionate, loving, peaceful person, changed drastically a few months after I entered the profession. Majority of nurses shows anger and sadness, is miserable and morbid and does not match the image I had before."*
- The same student furthermore asked the question*: "…did nurses then became so strained from giving too much care, that they have no more care?"*

According to Bloom's Taxonomy of the affective learning domain (Anderson, Krathwohl, Airasian, Cruikshank, Mayer, Pintrich, Raths and Wittrock, 2000), the analysis of the results of this study is that students from the junior and senior groups meet the requirement to **receive phenomena** (awareness and experiences of caring behaviours), which is **level one** in the affective learning domain. Most of the students from both groups comply with **level two** (**responding** to discussions about caring behaviour), which were evident in their responses to the questions during the focus group interviews. Most respondents also comply with **level three** (**valuing** the importance of having caring behaviour). However, **level four** (**organization** — comparing, relating and synthesising – of own caring behaviours with other values) and **level five** (**internalisation** and characterisation of the value, which are displayed on a daily basis) could not be verified as processes that are inherently part of the students' value systems.

55

There are not many efforts cited in literature to support the internalisation of caring values in nursing curricula (Brown, 2011). Cook and Cullen (2003) attempted to enhance the internalisation process by including Watson's Caritas Processes (Dinapoli *et al.,* 2010) and applying competencies of the affective learning domain (Anderson *et al.*, 2000) into the academic plan of a group of students. However, these hierarchically affective learning competencies of caring behaviour have not been explored much further than Murphy *et al.* in 2009 (Brown, 2011). There seems to be a shortcoming in the mentioned undergraduate nursing curriculum in developing affective competencies through educational processes, which should support the growth of caring affective abilities (Brown, 2011).

As a central component of nursing, caring behaviours provide the direction for the nursing profession's growth (Wade and Kasper, 2004), but knowledge and techniques to teach and assess in the affective domain is invisible (Mogodi, Jooste and Botes, 2009). However, theorists have been in agreement since the 1990s that caring behaviours are learnt by being exposed to patient care interactions that demonstrate caring in the clinical environment.

In addition, when supported by a caring educational environment, Wade and Kasper (2004) postulates that students will learn professional values, like caring behaviours. Cook and Cullen (2003) reflected on how student nurses learn caring behaviours through their training programmes. Upon commencement of training, a caring training institution will assist the students to develop a personal definition of caring. As students then progress through the programme the definition broadens and can be applied to individual patients, while patient care is rendered, and caring behaviours illustrated by other nurses can be witnessed. The researcher agrees that this pathway should broaden the student nurses' understandings and internalisation of caring behaviours.

5.5. Recommendations for further research

Since various qualitative research done on caring agree that, if students are working and studying in environments where there are caring relationships between the academic staff and the students, the development of professional values is enhanced (Wade and Kasper, 2006). Future research should include the level of knowledge of, and the teaching, learning and assessment competencies of nurse educators around professional values, like caring behaviours. Finfgeld-Connett (2008) did a meta-synthesis of 49 reports on qualitative studies and six caring concept analyses. It was concluded that the assumption is that patients' and nurses' wellbeing can potentially improve through caring experiences.

Therefore it would also be recommended, after this current study, that further studies should be undertaken to determine whether caring behaviours in students, role modelling of these behaviours in nurse educators, as well as teaching and assessment strategies of caring, would change the outcome of a patient's hospital stay, in terms of patient satisfaction, length of stay in the hospital and recovery time.

5.6. Limitations of the study

This study took place at only one private nursing education institution (NEI) where the participating students, who are registered, attend theoretical contact sessions throughout the academic year. Although the students are placed in various private hospitals in the Western Cape for the experiential learning hours, the findings may not be generalisable to all first- and fourth-year nursing students as other NEI's did not participate in the study. In order to be able to follow the natural growth of the internalisation process of caring behaviours from first- to fourth-year, it would have been valuable if a longitudinal study was done; namely that a sample of the fourth-year nursing students, who participated in this study, were interviewed on their caring behaviours during their first-year of study.

Although the heterogenic nature of the focus interview groups were decided upon and selected by the researcher, to ensure richness of the conversations, it also could have been interesting to explore the differences in the perceptions about caring behaviours from different cultures, age groups, gender, marital statuses and base hospitals perspectives. As justified in the study, it was also predetermined by the researcher not to inform the participants and the interviewer that the participants' responses about their caring behaviours would be grouped according to Watson's Caritas Processes. However, the researcher reasons that, should the participants have had the opportunity to be exposed to these Caritas Processes after the interview in a follow-up session to do a self-assessment, it would have added value to the study and to the participants.

5.7. Recommendations

Perceptions of caring behaviours must be reviewed regularly by students and facilitators. The literature is clear about the fact that students and facilitators should regularly reflect on their perceptions of caring behaviours, in order to enhance the internalisation process. The researcher is of the viewpoint that the discussions during the focus group interviews for this study already enhanced the internalisation process in the two groups of students and joins Ranheim, Kärner and Berterö (2012) by recommending that **reflections on caring behaviours should be recorded and compared with reflections done later in the academic programme**.

This will encourage student nurses to understand her/his own caring behaviours and to develop as a caring professional nurse. The identified caring behaviours and attributes from this study and Watson's 10 Caritas Processes can be used **to guide student nurses and educators when reflecting on their own caring behaviours during nurse-patient interactions**. Potentially, **assessment practices of caring behaviours** could consequently also be guided by these identified factors and processes.

From the literature review done for this study, the challenge to integrate the affective learning domain into the nursing curriculum was identified. **The outcome of this present study also reiterates that nursing education programmes should include the teaching and assessment of professional values, like caring behaviours, to facilitate the internalisation process of professional behaviours in nursing students.** Nursing educators should receive appropriate training to facilitate strategies to learn these behaviours, for example role modelling, role playing, value clarification and reflection.

Furthermore, the findings of this study indicate that students value gestures of feedback on caring behaviours from patients, unit managers and peers. In addition, it was also evident from the students' responses that patients value behaviours and attitudes of care portrayed by the nursing staff. Therefore, it is my final recommendation that **caring cultures must be cultivated in educational institutions and among students and employees**.

5.8. Summary

According to Watson's 10 Caritas Processes, the first- and fourth-year nursing students who participated in this study, are generally caring and regard caring behaviours as important. However, whether internalisation and characterisation (Brown, 2011) of the caring behaviours developed from year one to year four could not be determined in this study, because there were no significant differences in the perceptions of caring behaviours between the junior and the senior groups. Consequently, after this analysis of what caring behaviours entail, this study suggests that there is a change in emphasis in some caring components, as the nursing students progress to later years of studies. These components include communication skills, maybe because it is overtly included in the learning outcomes from the first year of studies. Ma, Li, Liang, Bai and Song (2014) reminded professional nurses that nursing students should learn how to care in order to live out a personal philosophy, and to experience professional and personal satisfaction.

Finfgeld-Connett (2008) is of the opinion that caring behaviours is not a transmittable trait, and that it must be taught and cultivated. This illustrates that to have caring behaviours is not only important for patient wellbeing, but also for the nurse and nursing student's sense of fulfilment (Ma *et al.*, 2014). Therefore, if the essence of nursing is care, it is indeed the nursing educators' and nursing curricula's responsibilities to ensure that caring, as an affective behaviour, becomes as visible as the cognitive and psychomotor domains of nursing education through sound teaching and assessment strategies.

6. List of resources

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ADDENDUM A: **Demographic information of participants**

Demographic information of participants

_____   **Age**

Demographics: Circle the appropriate descriptor

A.   Female   B.   Male

A.   Black   B.   Asian   C.   White   D. Colored

A.   Married   B.   Single

Programme: (mark applicable programme with x):

_____   **First year** (after 6 months of training completed)

_____   **First year** (after 11 months of training completed)

_____   **Fourth year** (after 23 months of training)

_____   **Fourth year** (after 18 months of training)

ADDENDUM B: **Guide for focus group interview with nursing students**

<u>Guide for focus group interview with nursing students</u>

The researcher will use the questions as a guide and not necessarily in a specific order.

Questions:

1. In your opinion, what do you believe are caring behaviours? What actions or behaviours might nurses demonstrate as caring?
2. How would you like to be assessed about caring?

Prompting questions:

    1.   How do you know that you are a caring nurse?

    2.   Please tell me a bit more about this.

    3.   Is there anything else you would like to add to this?

Thank you.

69