

**TRANSFORMATION AND EMBODIMENT: NURSING STUDENTS' LIVED
EXPERIENCES OF LEARNING CARING IN NURSING EDUCATION**

by

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Bachelor of Nursing, University of New Brunswick, 2006

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

Master of Nursing

in the Graduate Academic Unit of Nursing

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This thesis is accepted by the
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THE UNIVERSITY OF NEW BRUNSWICK

December, 2018

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Abstract

Given the importance of caring in nursing, it was necessary to understand the lived experience of learning caring in nursing education. To promote meaningful learning in nursing education, knowledge about nursing students' experiences of learning caring was necessary. Research related to the phenomenon of learning caring for nursing students was minimal, therefore a need existed for further description and understanding of learning caring from nursing students' perspectives. This research study was conducted to explore the question, "What is it like for bachelor of nursing students in a four year program to learn caring in a curriculum that has caring as a core value?" The aims of the study were to understand: the meaning of caring for nursing students; the meaning of learning caring for nursing students; factors within nursing education that facilitate and/or limit learning caring for nursing students; and how caring is lived from the nursing students' perspectives within a curriculum that has caring as a core value. van Manen's (1997) qualitative phenomenological research approach was employed. In particular, selective thematic analysis, as described by van Manen was used to better describe and understand the lived experience of learning caring for nursing students. The lived experience of learning caring was made up of two phenomenological themes including a transformation in their meaning of caring and embodiment of caring. In addition to nursing students' lived experiences of learning caring, curriculum documents were analyzed for the presence and absence of caring language. Curriculum documents provided important context to the lived experience of learning caring. Factors that facilitated and/or limited learning caring are offered along with implications for nursing education, education administration, practice, and research.

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Transformation and Embodiment: Nursing Students' Lived Experiences of Learning Caring in Nursing Education

Caring is viewed as the essence of nursing (Boykin & Schoenhofer, 2013; Leininger, 2012; Sumner & Fisher, 2008; Watson, 1988; Sitzman & Watson, 2018). Without caring, nursing can seem routine or inauthentic (Kahn & Steeves, 1988; Nelms, 1996). Given the important nature of caring in nursing and the consequences of nursing without caring, it is necessary to understand caring as it is learned in nursing education. Specifically, knowledge about nursing students' experiences of learning caring is necessary to promote meaningful learning in nursing education. Research related to the phenomenon of nursing students learning caring is minimal, therefore a need exists for further description and understanding of learning caring from nursing students' perspectives. To address the gap in research evidence, this research study was conducted to answer the question: "What is it like for bachelor of nursing students in a four year program to learn caring in a curriculum that has caring as a core value?" To answer this question a qualitative phenomenological research approach, specifically van Manen's (1997) approach was employed. Below is an in-depth description of the research study including a background of caring in nursing, a literature review of research related to nursing students' experiences of learning caring, a description of the research methods guided by van Manen's (1997) research methodology, findings from this study, a discussion about the findings, and implications for nursing education, administration, practice, and research.

Chapter 1: Background and Significance

Although caring is essential to nursing, it is difficult to provide a definitive definition. In general terms, as a noun, caring has been defined as, *the work or practice of looking after those unable to care for themselves, especially on account of age or illness* (Caring, 2010). As an adjective caring has been described as, *displaying kindness and concern for others* (Caring, 2010). Leininger (1991) identifies the word caring as a gerund. A gerund is a verb that acts as a noun ending in *ing* (Gerund, 2010). Within the context of nursing, caring is defined in a variety of ways through theoretical perspectives (Boykin & Schoenhofer, 2013; Leininger, 1991, 2012; Sumner & Fisher, 2008; Watson, 1988) and nursing practice (Blum & Gordon, 2009; Covington, 2005; Engebretson, 2000; Kahn & Steeves 1988). In addition, conceptual analysis of caring has been conducted (Finfgeld-Connett, 2007, 2008a, 2008b). Although many definitions of caring are offered in the literature, for this study, caring was not defined a priori. Instead, I aimed to learn about and document the meaning of caring and learning caring based on data from the interviews and curriculum documents. Findings and a discussion about the meaning of caring as derived from the curriculum documents and participants' experiences are presented in Chapter four (Findings) and Chapter five (Discussion).

Having said this, because caring has been shown to result in positive consequences for nurses (Finfgeld-Connett, 2007; Sumner & Fisher, 2008), nursing students (Blum & Gordon, 2009; MacNeil & Evans, 2005; Mlinar, 2010), recipients of care (Engebretson, 2000; Finfgeld-Connett, 2007, 2008a, 2008b), and the work and organizational environment in general (Engebretson, 2000; Finfgeld-Connett, 2007, 2008a, 2008b), this study was guided by an understanding and belief that caring is beneficial to nursing. Likewise, an understanding that uncaring, or lack of caring, is not

beneficial to nursing was also foundational to informing the study. In the following sections, consequences of caring and uncaring in nursing are described in further detail. Factors that facilitate and/or limit caring are also described.

Consequences of Caring Nursing: Nurses and Nursing students

A concept comparison was conducted using qualitative research and linguistic analysis of caring and social support, and an outcome of caring common across the analyzed research, on the part of the nurse, was psychological wellbeing manifested as satisfaction, growth, and enthusiasm (Finfgeld-Connett, 2007). Blum and Gordon (2009), suggested that nursing students' experienced positive outcomes related to caring in nursing. Through witnessing caring, for example between a nurse and patient or a nurse and student, nursing students demonstrated growth and an increased understanding of themselves as caring beings in need of caring. When nursing students felt cared for, their ability to care for others was optimized (MacNeil & Evans, 2005). Overall, in the literature, when caring was present, nurses and nursing students experienced transformation, understanding that nurses, nursing students, and recipients of care were vulnerable and in need of caring (MacNeil & Evans, 2005; Mlinar, 2010; Sumner & Fisher, 2008).

Consequences of Caring Nursing: Recipients of Care

Using existing qualitative research and linguistic analyses, concept analyses of caring in nursing were conducted and a common outcome of caring for recipients across the literature was mental and physical wellbeing (Finfgeld-Connett, 2007, 2008a, 2008b). Physical wellbeing was characterized by having physical needs met, increased independence or self-care, and being empowered (Finfgeld-Connett, 2007, 2008a, 2008b). Mental wellbeing included feeling competent, having diminished stress,

effective coping, increased self-esteem, and psychic growth (Finfgeld-Connett, 2007, 2008a, 2008b). In another study, Engebretson (2000) concluded that overall patient satisfaction was improved when nurses were caring in their practice.

Consequences of Caring Nursing: Environment

The environment in which caring occurs is also impacted. At a local or unit level an immediate calm can be experienced (Engebretson, 2000). Finfgeld-Connett (2007, 2008a, 2008b) concluded through a concept analysis that work environments were affected by caring in positive ways by increasing nurses' and patients' wellbeing. In turn, nurses' and patients' wellbeing made environments more conducive to caring. Engebretson (2000) reminds us that caring at a local level had the potential to impact an entire nursing unit in a positive way. Despite the importance of caring in nursing, nursing without caring or uncaring nursing exists. Knowledge about the consequences of uncaring is important to better understand the lived experience of uncaring. Following is a discussion about the consequences of uncaring for nursing and nurses.

Consequences of Uncaring Nursing: Nursing and Nurses

Despite the importance of caring in nursing, nursing without caring or uncaring nursing exists. Uncaring nursing has been described as inauthentic (Nelms, 1996) or acting in a routine way (Kahn & Steeves, 1988). In Kahn and Steeves (1988) study, nurses characterized uncaring in a nurse/patient relationship as a mutual inability to get along. For nurses in Sumner's (2008) study, nursing without caring, resulted in feelings of malcontent that manifested as anger, frustration, and/or criticism directed at others. Also in Sumner's (2008) study, in circumstances when nurses experienced malcontent, they indicated that they felt powerless; however the nurses did not articulate how their control and power impacted caring or uncaring in the nurse/patient relationship. This

may be reflective of a lack of awareness, on the nurse's part, of the important role they play in creating and maintaining caring in the nurse/patient relationship.

To enhance the consequences of caring and to mitigate the consequences of uncaring, it is important to know more about factors that facilitate and/or limit caring. In the literature, factors that facilitated caring included nursing education and faculty members. Factors that limited caring included liking as a basis for caring, organizational demands and values, and nursing education. Factors are discussed in detail below.

Factors that Limit Caring Nursing: Liking as a Basis for Caring

Kahn and Steeves (1988) posited that liking as a basis for caring could contribute to a lack of caring. That is, if a nurse and patient do not like one another, caring might not occur. Those same nurses indicated that a patients' actions, such as an unwillingness to communicate, acted as a barrier to caring (Kahn & Steeves, 1988). Perhaps this explains what Finfgeld-Connett (2008a) meant when they suggested that the recipient of care must be open to receiving care; if the recipient of care does not like the nurse or vice versa, caring may be limited or non-existent. For example, for a graduate nursing student in Kahn and Steeve's (1988) study, if a patient liked the nurse, the patient offered verbal praise or even became friends with the nurse.

If liking is a basis for caring, concerns might arise if a patient has been labeled as difficult. Nurses might find it challenging or impossible to form caring relationships with patients who have been labeled as difficult. In one study, nurses deemed patients as difficult if patients did not comply with advice or interrupted the nurses' routines (Michaelson, 2012). Nurses then engaged in emotional distancing or avoidance from patients whom they labeled as difficult (Michaelson, 2012). One nurse described their struggle to engage in *professional distancing while still caring* (Michaelson, 2012, p. 94)

and reflected on their limited communication with the patient and their experience of a value conflict. Some nurses viewed emotional distancing as an appropriate means to cope with the demands from patients and the workplace (Michaelson, 2012).

Factors that Limit Caring Nursing: Organizational Demands and Values

Kahn and Steeves (1988) stated that value conflicts that limited caring nursing arose when nurses were forced to weigh organizational values against caring. Sumner (2008) suggested that organizational values related to efficiency, productivity, and objectivity acted as barriers to caring. For example, organizational constraints such as a lack of time and human and physical resources made caring feel impossible or even discouraged (Sumner, 2008). Thus, some nurses were caught between satisfying organizational demands and patient needs, causing value conflicts. Researchers suggest that value conflicts could cause some nurses to experience contradictions and tension, possibly leading to apathy and dissatisfaction if not resolved, that may negatively impact caring in nursing (Kahn & Steeves, 1988; Sumner, 2008).

Nurse caring was also limited by a perceived need among some nurses to remain objective and to pay little or no attention to the subjective nature of nursing (Kahn & Steeves, 1988). In Kahn and Steeves (1988) study, some nurses experienced tension between getting close to patients and remaining objective. They felt an obligation to give unconditional care while simultaneously applying prerequisites for caring –such as liking as a basis for caring (Kahn & Steeves, 1988).

Other organizational factors that limited caring in nursing included a focus on complicated procedures, a future orientation to time, and valuing material over immaterial resources (Engebretson, 2000). Nurses perceived that their competence was often measured by their skills at completing complicated procedures instead of their

ability to be caring with someone in the moment (Engebretson, 2000). Nurses noted that they were expected to focus on planning, scheduling, and preparing for future tasks, which also impacted their ability to be caring in the moment with patients (Engebretson, 2000). There was also a perception among the nurses in this study that organizations tended to value material resources, those that are measurable and can be seen, over immaterial resources such as caring, which can lead to immaterial resources being trivialized or ignored (Engebretson, 2000). Balancing caring with organizational values left nurses feeling vulnerable and in need of thoughtful consideration (Sumner & Fisher, 2008). Nurses wanted to practice high quality nursing care that maintained the values of caring and the organization, but not at the expense of their own wellbeing (Sumner, 2008).

Factors that Limit Caring Nursing: Nursing Education

A number of researchers have suggested that if caring is not intentionally integrated in nursing education, it is possible that the education experience can inhibit or decrease students' caring abilities (Ma, Liang, Bai, & Song, 2014; Murphy, Jones, Edwards, James, & Mayer, 2009). For example, results from a cross-sectional study that compared a cohort of first year nursing students to a cohort of third year nursing students revealed that third year students reported lower scores on the Caring Behaviors Inventory (CBI) tool; these differences were statistically significant in the 17 to 25 year age group (Murphy et al., 2009). The authors suggested that differences in caring behaviours among first and third year students may be related to occupational socialization and dissonance between caring ideals and the reality of nursing. The authors described occupational socialization as the process by which nursing students internalized the beliefs and values of the nursing culture. Dissonance occurred when

students' ideals were tempered by the real life challenges of nursing practice (Murphy et al., 2009). Although these data revealed that, for some nursing students, caring diminished over the course of their nursing education, there is also evidence to suggest that nursing education can facilitate and/or promote the development of caring nursing.

Factors that facilitate Caring Nursing: Nursing Education

Nursing students reported feeling cared for by nurse educators when a caring pedagogy existed (MacNeil & Evans, 2005) and opportunities to apply caring were integrated in the classroom (Adamski, Parsons, & Hooper, 2009; Lee-Hsieh, Kuo, Turton, Hsu, & Chu, 2007; Stowe, 2006), online (Sitzman, 2010; Sitzman & Leners, 2006; Sitzman & Watson, 2017), practice (Hwang, Wang, & Lin, 2013; Lindberg, Persson, & Bondas, 2012; Porr & Egan, 2013), and lab settings (Minnesota Baccalaureate Psychomotor Skills Faculty Group, 2008). For some nursing students, a caring pedagogy in nursing education was relational and took place within the student and nurse educator relationship (MacNeil & Evans, 2005). A caring pedagogy enhanced nursing students experiences of learning caring and was characterized by connectedness, support, presence, respect, and growth (MacNeil & Evans, 2005).

Many authors agree that caring nursing can be promoted through specific courses that focus on caring (Lee-Hsieh et al., 2007; Stowe, 2006; Wu, Chin, & Chen, 2009). Caring courses designed to facilitate students' understanding and application of caring concepts inside and outside the classroom setting (Lee-Hsieh, Kuo, Turton, Hsu, & Chu, 2007; Stowe, 2006; Wu, et al., 2009) include instructional methods such as role modeling, discussions, journaling, simulations, readings, and involved students' applying caring skills and concepts outside the classroom setting (Lee-Hsieh, Kuo, Turton, Hsu, & Chu, 2007; Stowe, 2006); for example, conducting a campus caring

assessment (Stowe, 2006). Findings suggested that students learned caring, which was evidenced by an increased understanding of caring (Stowe, 2006), an increased agreement with caring behaviours (Wu et al., 2009), and embodiment of the caring values taught in the course (Lee-Hsieh, Kuo, Turton, Hsu, & Chu, 2007).

Caring nursing was promoted when nurse instructors conveyed caring in the context of an online course (Sitzman, 2010; Sitzman & Leners, 2006; Sitzman & Watson, 2017). Students reported instructor behaviours such as timely feedback and reciprocal caring as important caring behaviours (Sitzman, 2010; Sitzman & Leners, 2006). Preferred caring behaviours were very similar to best practice recommendations for online instruction (Sitzman, 2010; Sitzman & Leners, 2006). The authors found that nursing students' understanding of caring was enhanced when online instructors conveyed caring behaviours (Sitzman, 2010; Sitzman & Leners, 2006; Sitzman & Watson, 2017).

Some researchers have examined specific instructional methods for their effectiveness in promoting caring nursing (Adamski et al., 2009; Hwang et al., 2013; Minnesota Baccalaureate Psychomotor Skills Faculty Group, 2008). Examples of instructional methods that resulted in students learning caring included hearing and reflecting on nurse narratives about caring (Adamski et al., 2009) and integration of caring in the lab setting via instructors role modeling psychomotor skills in caring and uncaring manners (Minnesota Baccalaureate Psychomotor Skills Faculty Group, 2008).

Caring within the clinical or practice setting can also have a major impact on promoting caring nursing (Lindberg et al., 2012). For example, Lindberg et al. (2012) found that without intentional integration of caring on the part of both the university and clinical settings, students felt they were left to learn caring on their own. Related to this,

Porr and Egan (2013), in their study focused on the assessment of caring abilities, suggested that caring in the practice setting can be enhanced when faculty members have a means to assess students' caring abilities and thus also highlighting the importance of intentional integration. The role of faculty members in promoting caring nursing is discussed in more detail in the next section.

Factors that Facilitate Caring Nursing: Faculty

Individual faculty members played a very important role in students learning caring. A number of researchers have found that if faculty members were caring with and toward students, students felt more equipped and supported to care for patients in the practice setting (Labrague, McEnroe-Petitte, Papathanasiou, Edet, & Arulappan, 2015; Livsey, 2009; MacNeil & Evans, 2005). As instructors' role modeled caring, students felt motivated and empowered to be caring (Labrague et al., 2015). Faculty maintained the potential to either facilitate or inhibit caring depending on the extent to which they engaged in caring.

To support faculty to further promote caring nursing, it may be helpful for faculty members to have access to tools that assess students' caring abilities. A tool that is showing promise for this purpose is the Caring Interaction Inventory (Porr & Egan, 2013); an assessment tool is offered that could provide a language with which to discuss caring abilities as they relate to nursing practice.

For faculty members to intentionally integrate caring into their teaching it is suggested that they undergo systematic training in caring theory and practice (Lee-Hsieh et al., 2007; Livsey, 2009). This training could help faculty members internalize caring, which, in turn, could result in an increase in their own caring abilities while simultaneously expanding their ability to teach caring. If faculty members are not

encouraged or prepared to teach caring, caring may be viewed as someone else's responsibility such as registered nurses and preceptors in the practice setting (Lindberg et al., 2012). This could be problematic because, based on their work, Lindberg et al. (2012) have suggested that registered nurses, senior preceptors, and head nurses in the practice setting view teaching caring as the responsibility of faculty members. If neither faculty nor nurses in practice settings view teaching caring as their responsibility, students may be left to learn caring independently or may not learn caring at all. To better understand nursing students' experiences, literature related to student views of learning caring was examined and is presented in the next chapter (Literature Review).

Chapter 2: Literature Review

The literature review was conducted to answer the question, “What literature already exists related to nursing students’ lived experiences of learning caring?” The literature search was conducted using three databases including Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, and Education Resource Information Center (ERIC). CINAHL and Medline were chosen based on their relationship to health care and ERIC was chosen based on its relationship to education. The search was limited to dissertations and published articles and no date limitations were applied. Articles were excluded from the literature review if they were not written in English and did not pertain to the three main ideas of the research question, which were nursing students, learning, and caring. Search strategies were similar across all databases with slight variations in search terms depending on the database. The search terms were tailored based on the format of terms used in each database, for example with CINAHL, Medline, and ERIC, CINAHL headings, MESH terms, and thesaurus terms were used respectively. Titles and abstracts were reviewed and articles that did not meet the eligibility criteria (three main ideas) were excluded. After removing duplicates and receiving an additional article from the internal reader for the proposal phase of this project, a total of 11 papers and articles based on eight research studies informed the development of the literature review. Search methods and results for each database are outlined in Appendix A. Related to nursing students learning caring, themes that arose from the literature review can be organized into two categories including the meaning of caring for nursing students and the meaning of learning caring for nursing students. Below is a discussion about those meanings.

The Meaning of Caring for Nursing Students

In many cases the learning caring literature included a focus on students' meanings of caring (Allis, 1992; Drumm, 2006; Drumm, & Chase, 2010; Kosowski, 1993, 1995). It was suggested that students needed to reflect on their meanings of caring before they could reflect on their meaning of learning caring. In two studies, students ideas of caring were elicited through interview questions (Allis, 1992; Drumm, 2006; Drumm, & Chase, 2010); however in one study students offered their ideas without prompting from the researcher (Kosowski 1993, 1995). For some students the meaning of caring was represented by seven themes; connecting, sharing, being holistic, touching, advocating, being competent, and feeling good (Kosowski, 1993, 1995). Other students' described caring as trust, honesty, and balance (Allis, 1992). In another study, students experiences were described by a theme, innate knowing of self as caring. This theme was characterized by three subthemes; being present for the patient, being open to reshape the patient's experience, and an enhanced capacity to care (Drumm, 2006; Drumm, & Chase, 2010). In addition to the meaning of caring, the meaning of learning caring for nursing students emerged from the literature review.

The Meaning of Learning Caring for nursing students

Across the studies included in this review, themes about nursing students learning caring emerged that captured the meaning of learning caring for nursing students. The themes that emerged were sex and gender, transformation, self, creativity, a conducive learning environment, role modeling, uncaring encounters, and experiential knowledge.

Sex and gender. A stereotypical gender assumption that women are better than men at caring continues to exist and because of this assumption caring has often been

viewed as the work of women (Allis, 1992; Paterson et al. 1995, 1996). This has brought about questions related to men's caring abilities as nursing students and whether or not men and women nursing students learn to care in the same way (Paterson et al., 1995, 1996). To address this gap, Patterson et al. (1996) conducted a secondary analysis of existing data to explore the experiences of learning caring for nursing students who identify as men. Nursing students in Patterson et al.'s (1996) study reported that they experienced learning caring differently, and caring as a man was characterized by three themes; gender differences, experiencing the difference, and being prepared for the difference. Differences included being turned away by patients based on sex, risking a macho identity by displaying caring, and displaying caring behaviours such as touch without sending the wrong message (Paterson et al., 1996). While Paterson et al.'s (1995, 1996) work focuses on men, more work examining gender as a social construct, and the varied ways gender influences men's caring, needs to be done. Further, it is important to recognize that, to date, research related to learning caring has examined differences in caring between women and men and thus the experiences of individuals who do not identify with this binary have been largely ignored.

Transformation. Transformation was characterized by an epiphany (Lake, 2004), heightened awareness or consciousness (Kosowski, 1993, 1995), or new insights and coherence (Eskilsson, Horberg, Ekebergh, & Carlsson, 2014). Students' thinking and behavior in clinical practice were transformed as students reported maturation from the nursing student role towards the nursing role (Eskilsson et al., 2014).

Transformation in learning caring was invaluable in helping students deepen and broaden their caring abilities (Kosowski, 1993, 1995). Transformation often took place during or after an uncomfortable or distressing experience, such as witnessing inequities

in society (Kosowski, 1993, 1995) or an uncaring moment in clinical practice between a nurse and patient (Paterson et al., 1995). Aha encounters were also transformational and occurred when students' ideals of caring did not align with what was actually happening in nursing practice (Paterson et al., 1995). Students went through a process of confusion and uncertainty about their ideas of caring that included reflection on the right answer and discovery about how to integrate new assumptions and let go of previously held ones (Paterson et al., 1995). Kosowski's (1993, 1995) theme, sensing, involved becoming aware of one's feelings and assumptions as they arose during nursing practice. Through a heightened awareness, students were more open to their own and patients' feelings and needs. This resulted in the students being more sensitive to, and in tune with, their environment and patients' unique context (Kosowski, 1993, 1995).

Self. Drumm (2006) and Drumm and Chase (2010) described learning caring as coming to know self as caring. Knowing self as caring involved being present with patients, being open to reshaping the experiences of patients, and enhancing one's caring ability. In the clinical setting students needed to recognize the needs of patients and their own ability to care for those needs (Eskilsson et al., 2014). For some students self was described in terms of feeling good when caring for others (Kosowski, 1993, 1995); and for other students, self was represented by a need to be cared for (Paterson et al., 1995). Solvoll and Heggen (2010) concluded that some nursing students' self-motivations were not altruistic, but rather egoistical; students cared because it felt good. In another study students' self emerged from the data as a need for self preservation and a need to feel motivated by their nursing supervisor (Eskilsson et al., 2014). Self-preservation involved a transformation in thinking and behaviour while still preserving a piece of one's identity. In doing this, students were seeking their own style of caring

(Eskilsson et al., 2014). Students' motivation was enhanced through confirming and affirming responses from clinical supervisors such as supervisors providing feedback that let the student know they were on the right track.

Creativity. Students learned caring through creative learning modes such as writing, aesthetic projects, and reflection (Drumm, 2006; Drumm, & Chase, 2010). Imagining, a cognitive process described by Kosowski (1993, 1995), involved students using their imagination to draw on their own life experiences to learn caring. Through this creative process, students were able to gain insights into the patients' need for caring.

A conducive learning environment. Many researchers reported that learning caring occurred when caring theory and opportunities to practice caring were intentionally integrated in nursing education curricula (Drumm, 2006; Drumm, & Chase, 2010; Kosowski, 1993, 1995; Lake, 2004; Ma et al. 2014; Paterson et al., 1995). Transformative learning, for nursing students, seemed to occur most often in the clinical or practice settings where students' caring ideals were challenged (Drumm, 2006; Drumm, & Chase, 2010; Kosowski, 1993, 1995, Ma et al., 2014), and where caring was practiced, or where students made sense of themselves as caring (Drumm, 2006; Drumm, & Chase, 2010; Eskilsson et al., 2014; Ma et al., 2014; Solvoll & Heggen, 2010). Students' confidence and caring abilities grew as they came to know themselves through practicing caring (Drumm, 2006; Drumm, & Chase, 2010; Ma et al., 2014).

In the learning environment, many researchers agreed that it was imperative that students were provided with the necessary tools and opportunities to implement caring (Drumm, 2006; Drumm, & Chase, 2010). Opportunities for engagement in dialogue, reflection, feedback, and critical thinking about caring in the practice setting were of

significant importance in learning caring (Eskilsson et al., 2014; Ma et al., 2014, Paterson et al., 1995; Solvoll & Heggen, 2010). If opportunities for dialogue were not provided in practice and instead there was a focus on tasks and problem solving, students were left to learn caring on their own (Solvoll & Heggen, 2010). In addition, students needed to feel safe in their environment. The nursing supervisor needed to create a secure atmosphere in which a balance existed between *monitoring and permitting* (Eskilsson et al., 2014, p. 85).

Role modeling. Role modeling was the most frequent instructional method that appeared in the literature for learning caring (Allis, 1992; Drumm, 2006; Drumm & Chase, 2010; Kosowski 1993, 1995; Ma et al., 2014). For some nursing students, role modeling occurred through observation and imitation of caring instructors (Kosowski, 1993, 1995), professors (Paterson et al., 1995), nurses (Allis, 1992; Kosowski 1993, 1995; Paterson et al., 1995), and peers (Paterson et al., 1995). Clinical instructors were identified as having a major impact as role models because their caring with patients and students could influence the whole learning experience (Eskilsson et al., 2014; Kosowski 1993, 1995). Paterson et al. (1995) described that students who were men relied more on their peers and nurses for role modeling because they viewed their instructor as the choreographer of learning, not necessarily involved in direct patient care. Also, for nursing students who were men having a role model who was also a man was very valuable. It was found that nurse role models who were men were rare in the nursing practice and education settings (Paterson et al., 1995).

Uncaring encounters. Students also described uncaring encounters and how the encounters contributed to learning caring (Kosowski, 1993, 1995; Ma et al., 2014). Reversing (Kosowski, 1993, 1995) and negative role modeling (Ma et al., 2014;

Paterson et al., 1995), referred to students' learning from uncaring encounters through engagement in dialogue, critical thinking, and reflecting on the encounters. Students spoke about powerful emotions they experienced when witnessing an uncaring encounter that made them reflect on their own practice as nurses (Kosowski, 1993, 1995). Kosowski's (1993, 1995) term reversing, referred to a cognitive process students engaged in to reverse the negative role modeling in order to temper the powerful emotions they felt during uncaring encounters. Through reversing negative role modeling, students learned something positive about caring (Kosowski, 1993, 1995; Ma et al., 2014; Paterson et al., 1995). It made them think and talk about how they would integrate caring into their future nursing practice. Another example of when an uncaring encounter was used as a learning opportunity was described as aha encounters. Paterson et al. (1995) described an aha encounter as an experience in which students were forced to reconcile the difference between their caring ideal and what was happening in the reality of nursing.

Experiential knowledge. Students' experiential knowledge both personal and professional contributed to their learning caring (Allis, 1992; Kosowski, 1993, 1995). Specifically, students' life experiences, family experiences, and experiences with illness contributed to learning caring (Allis, 1992). Kosowski (1993, 1995) described this process as constructing. Constructing took place when students created caring by blending their past experiences, for example with family members, together with their nursing knowledge (Kosowski, 1993, 1995). In this way, students constructed knowledge and then acted based on their new understanding of the need for caring (Kosowski, 1993, 1995).

The results from this literature review support the notion that learning caring is complex and intentional instructional methods that promote students' meaningful learning of caring need to be integrated throughout the entire nursing education experience. To be intentional about teaching caring, nurse educators need to understand what it is like for nursing students to learn caring. Thus, this study was designed to gain a deeper description and understanding of the phenomenon, learning caring in a curriculum that has caring as a core value.

Chapter 3: Methodology and Methods

Given that we know the important nature of caring in nursing and the role nursing education plays in promoting caring, it is necessary to articulate and understand how nursing students learn caring in their nursing education experiences. For caring to be integrated in nursing curricula, and subsequently nursing practice, there is a need to develop knowledge related to learning caring. Given gaps in understanding surrounding the essence of learning caring for nursing students, it is important to seek a better understanding and description of this human phenomenon. By understanding the meaning for nursing students of learning caring, caring theories and experiences of teaching and learning caring practice can be developed and integrated in an intentional way throughout nursing curricula.

As identified in the literature review, minimal research literature exists and only eight studies were found that have specifically explored nursing students' lived experiences of learning caring. This study aimed to address this gap by describing and interpreting the meaning of learning caring as lived by bachelor of nursing (BN) students in a four year program with caring as an integral component of the curriculum. Data gleaned from this study may provide a basis for the development of instructional methods that can be intentionally integrated throughout nursing curricula. The research question was, "What is it like for BN students in a four year program to learn caring in a curriculum that has caring as a core value? The aims of the study were to understand:

- the meaning of caring for nursing students;
- the meaning of learning caring for nursing students;

- factors within nursing education that facilitate and/or limit learning caring for student nurses; and
- how caring is lived from the nursing students' perspectives within a curriculum that has caring as a core value.

The research question was explored using van Manen's (1997) human science phenomenological research approach. Following is a brief description of the philosophical underpinnings of phenomenology, which is then followed by a description of van Manen's (1997) phenomenological research approach as it relates to this study.

Philosophical Underpinnings

As a philosophy, phenomenology evolved out of protest to the traditional positivist paradigm that supported the separation of mind and body (Converse, 2012; Earle, 2010; Flood, 2010). Closely aligning with the naturalistic paradigm, phenomenologists believed that knowledge came from an interaction between subject and researcher and that there was no fixed truth; rather reality was based on individual and subjective realities (Converse, 2012; Flood, 2010).

Husserl described phenomenology as the science of pure consciousness (Reiners, 2012). For Husserl, the essence of the lived experience was derived from transcendental phenomenology in which knowledge stemmed from conscious awareness of an object and the meaning attached to that object. Husserl's phenomenology was concerned with knowing the world (Reiners, 2012). In keeping with the positivist approach he theorized that phenomenology required pre-reflective descriptions of phenomena. To maintain objectivity, researchers influenced by Husserl's philosophy were and are expected to epoché or bracket their foreknowledge of a phenomenon; to put it aside and meet the

phenomenon without judgment (McConnell-Henry, Chapman, & Francis, 2009; Reiners, 2012). Husserl supported the notion of Cartesian duality; a separation of mind and body or object and subject (Reiners, 2012).

A student of Husserl, Heidegger built on Husserl's notion of phenomenology and argued that phenomena must be understood beyond description; he sought to find meaning in the lived experience (McConnell-Henry et al., 2009; Reiners, 2012).

Heidegger's phenomenology was existential in nature. Pivotal to his thinking was the idea of existing or being in the world rather than knowing the world (Reiners, 2012).

The critical question for Heideggerian phenomenology was and is 'what is being?'

Based on the philosophies of Husserl and Heidegger, phenomenological research evolved as a way to study the human or lived experience (Converse, 2012; Flood, 2010). While Husserl supported pure description, Heidegger argued that description alone was not enough and that to gain knowledge one must seek to understand phenomena through interpretation (hermeneutics). Because Heidegger rejected Cartesian dualism, phenomenological reduction did not fit with his philosophy. Instead, Heidegger employed the hermeneutic circle as a way of understanding human experience. The hermeneutic circle involves a continual review and analysis between the whole and the parts of the experience (Reiners, 2012). Within the hermeneutic circle the observer cannot remove oneself from the phenomena, rather they become part of it (Reiners, 2012).

Nurses have relied on the philosophical underpinnings of phenomenology to conduct research and to develop research methodologies that guide inquiry (Dowling 2007; Earle, 2010; McConnell-Henry et al., 2009; Ortiz, 2009). Ortiz (2009) asserted that phenomenological research could expand nursing knowledge through increasing

understanding of the lived experience of nursing phenomena. In addition, phenomenological inquiry matches the aim of nurses, which is to better understand the experience of clients and patients (Dowling, 2007), leading to more meaningful nursing care (Converse, 2012). Because of its explorative and pedagogically oriented approach, many nurse scholars and educators have employed the phenomenological approach of Max van Manen (1997). van Manen is a notable Canadian researcher and educator who has developed a phenomenological human science approach that includes six research activities. To explore the lived experience of what is it like for bachelor of nursing students to learn caring, van Manen's (1997) approach was used to guide this study.

van Manen's Phenomenological Human Science Research Approach

van Manen's (1997) phenomenological human science research approach was chosen because it can effectively address the research question. Learning caring is a human phenomenon that has not been widely explored; therefore, it has an unknown nature. van Manen's (1997) methodology provides an opportunity to make the unknown known through an in-depth description and interpretation of the phenomenon. An in-depth description and interpretation of learning caring can significantly impact caring pedagogy in nursing education and allow the lived experience of learning caring to be captured in a textual form.

van Manen described phenomenology as *science that is concerned with 'persons', or beings that have 'consciousness' that 'act purposefully' in and on the world by creating objects of 'meaning' that are 'expressions' of how human beings exist in the world* (van Manen, 1997, p. 4). van Manen (1997) asserted that phenomenological human science involved getting to know the world, being the world, and becoming the world; thus, research is a caring act for which the researcher wants to

know and understand the essentials of being. According to van Manen (1997) the assumptions of phenomenological human science are: human life is understandable; human experience is more complex than what can be achieved in a single description; phenomenological human science is a comprehensive means of interpretive description meant to bring to our awareness the uniqueness and significance of human phenomena; phenomenological human science is concerned with the world as it is, *as we find it* (van Manen, 1997, p. 18); objectivity and subjectivity are not mutually exclusive; through humanizing human experience, humans can be more thoughtful and better prepared to act in situations; and phenomenological human science invites people to engage in dialogue. van Manen (1997) also explained that phenomenological human science is not an empirical analytic science concerned with speculative inquiry, particularity, or universality. It is also not a means for problem solving.

To pursue phenomenological human science research van Manen (1997) described six research activities. The first research activity is to commit one's self to a phenomenon of interest. To do this, researchers must choose a human phenomenon they are interested in and committed to knowing more about. The second activity is to investigate the lived experience rather than the conceptualized experience. This can be done through interviewing people who are experiencing the phenomenon. The next research activity is to reflect on the essential themes that characterize the lived experience of a phenomenon. Reflection, through writing and rewriting, results in a description and interpretation of the phenomenon being studied. It is during this process that data analysis occurs. The next activity is to *maintain a strong and oriented pedagogical relation to the phenomenon* (p. 31). A strong pedagogical orientation to the phenomenon holds the researcher accountable to conduct research that can be used to

directly impact and benefit students' learning experiences. The final research activity is *balancing the research context by considering the parts and whole* (p. 31). This means that each component of the research needs to be considered as a part of the greater research project. It is imperative to pay close attention to each detail as it relates to the greater research context. Although presented in a sequential manner, it must be noted that the researcher may not follow each step in sequential order, but rather be involved in many steps simultaneously. To elucidate the meaning of each research activity, the study is described below.

Turning to a phenomenon of interest. Turning to a phenomenon of interest requires a particular orientation to the phenomenon and is described as part of van Manen's (1997) research activity one. In my experience, I am oriented as a nurse educator. My orientation as a nurse educator cannot be separated from my interest in learning about caring in nursing education. Being a nurse educator, I am always in the world of being a nurse educator. An assumption of Heidegger's phenomenology is that it is not possible to bracket one's being in the world; therefore, a pre-understanding of my fore-structure or fore-conception related to the phenomenon of interest is necessary. This means reflecting on how I came to this point in research, including experiences from practice as a nurse educator with nursing students.

It is because of my own experiences as a nursing student, nurse, and nurse educator that I became interested in this area of inquiry. As a nursing student, I wanted to be caring, but I was unsure how to do so. Learning to be a caring nurse was left to chance. Although other skills, such as bathing, conducting dressing changes, and starting intravenous therapy, were the focus, I do not recall being explicitly guided to

practice these skills in a caring way. I was encouraged to remember the person with whom I was working, but how to do that was often left out.

As a new nurse on a busy acute medical unit, I remember being so focused on mastering efficiency and tasks, that my mind seldom intentionally considered how to do these tasks in a caring way. I did the usual check-in with people, *are you doing okay?*, but I often felt like I could be doing more to tend to patients' needs in a caring manner. It was not until I was reacquainted with theoretical knowledge as a nurse educator that the idea and importance of caring in nursing reemerged.

It was my experience as a confused nursing student and an overwhelmed novice nurse that helped me decide nursing education was where I needed to be, to positively influence nursing students, as they become caring nurses. Although I have transformed into a caring nurse through time and experience, I am still unsure of how to develop instructional methods that intentionally help students learn to be caring nurses. A major barrier is that I do not fully understand the experience of learning caring. At present, I attempt to teach caring through discussion and reflection on nursing situations, but I am not convinced this is the most effective teaching method, nor the only method. Becoming a caring nurse requires transformative learning; learning that transforms beliefs, attitudes, and behaviours about what it means to be a caring nurse. This effort requires intentionality on the part of educator and learner. Thus, my interest in knowing what it is like for nursing students to learn caring was born.

To enhance reflexivity, which is a process by which the researcher makes explicit their personal biases, beliefs, and values about the experience (Curtin & Fossey, 2007), I consciously identified and paid attention to my worldview and related assumptions and how this might impact my description and interpretation of the data (van Manen, 1997).

This involved questioning and reflecting on how my experience as a nursing student, nurse, and nurse educator might impact the collection and analysis of the interview and curriculum documents. The use of reflective journaling facilitated reflexivity (see Reflective Journal Guide, Appendix B) and occurred throughout the research process. Pre-reflective journal entries were made within 24 hours before each interview and post-reflective journal entries were made within 24 hours after each interview.

My reflections on the broad question, how might my experience as a nursing student, nurse, and nurse educator impact my analysis of this interview?, included:

- I value caring and think it is essential to everything we do in nursing
- I think all nurses should be caring
- I recognize that caring can look different from nurse to nurse and situation to situation
- Not all nurses or nursing students value caring in the way I value caring; some may not value caring at all
- Many factors impact caring and uncaring
- As a nursing student and novice nurse I was confused about caring; although I had an idea about caring, I struggled to balance caring with the demands of a busy acute medical nursing assignment
- As a nursing student and novice nurse, I did not believe caring could be learned. I thought if you were not naturally caring you could not learn to be caring; I was also not convinced caring could be unlearned until I struggled with my own caring
- I have experienced uncaring as a patient, family member, and nurse

- I have witnessed uncaring
- I have witnessed the consequences of uncaring
- I know caring can be viewed as “fluff” and not important or impossible considering the demands of nursing
- I know there are factors within health care settings that can hinder caring
- It is up to nurses to maintain caring; caring is internally motivated and must be intentional
- I become frustrated when nurses offer excuses to not care or to justify uncaring
- I have advanced knowledge about research related to caring and learning caring

By reflecting on my own experience and assumptions related to caring, I became more aware of my own values, beliefs, and biases. For example by knowing I value caring in nursing, during interviews with participants, I was intentional about not asking leading questions such as, “how do you value caring?” The question suggests that the participant values caring in some way. Instead I asked more neutral questions such as, “For you, what is the meaning of caring in nursing?” Also, through reflecting on the question: how might my experience as a nursing student, nurse, and nurse educator impact my analysis of this interview, I became more aware of a shift in my own thinking, a transformation. When I was a nursing student and novice nurse, I believed caring could not be learned. That it was an innate characteristic. I also did not believe caring could be unlearned. Then my own caring was challenged, and my thinking changed. I started to reflect more on caring, how it can be learned and unlearned and how it needs to be supported. I also began to develop a deepened view of caring that involved drawing on many theories about caring, instead of identifying with one theory

of caring, to inform my own meaning of caring and how I embody caring in nursing practice.

Maintaining a pedagogical orientation to the phenomenon. To ensure the research method was action oriented, it was important to maintain the idea of pedagogy at the forefront of my thoughts throughout the process. This is in keeping with research activity five as described by van Manen (1997). A commitment to developing a better pedagogic understanding of learning caring was maintained throughout the research process. To ensure the research was and is applicable to the real world of nursing education and the experiences of nursing students, I remained focused on the nursing students' experience at all times throughout the research process. This research is pedagogically oriented to students' lived experiences and concurs with van Manen (1997) when he cautioned against the abstraction of research stating it creates a barrier between research and application to the lived experience.

To stay true to the lived or real world experience of the nursing student, questions that maintained my orientation towards the participants were considered throughout the research process. Questions such as 'how will my approach with this student participant benefit or not benefit them?' and 'how can this student participant's experience of learning caring impact the pedagogy of learning caring in nursing education?' These questions and others were a part of the pre/post interview reflective journal (Appendix B). Reflections on the first question above are provided below. Reflections on the second question above are discussed in chapter six (Implications and Conclusions).

How will my approach with this student participant benefit or not benefit them?

- Benefit

- Opportunity to share and reflect on their experience related to caring and learning caring
- Opportunity to share, clarify, and reinforce meaning of caring in nursing
- Opportunity to debrief about uncaring encounters
- Opportunity to learn about and be a part of the research process
- May win a grocery store gift card
- Share what's important to them about caring and learning caring
- Have an opportunity to impact curriculum change
- Not benefit
 - May cause anxiety related to my role as an educator and/or their status as a nursing student
 - May experience fear about instructors and/or professors finding out what has been shared, especially in terms of uncaring encounters
 - Sharing about uncaring may bring up distressing feelings
 - May be challenging to fit the interview into their busy schedule
 - May experience anxiety about being recorded
 - May not win the gift card

Another way to ensure a pedagogical orientation was for me to maintain a thoughtful and respectful regard for the participants (van Manen, 1997); I was and continue to be caring with them. Through a pedagogical orientation to learning caring, the research will more likely result in action sensitive knowledge and ...*tactful thoughtfulness: situational perceptiveness, discernment, and depthful understanding* (van Manen, 1997, p. 156). This approach further facilitated the development of pedagogic competence in my role as a nurse researcher/educator (van Manen, 1997). To

this end, I reflected on the following question as part of the pre-interview reflective journal entry. How will I care for student participants before and during the interview process?

- Let them know this is private and confidential
- Reinforce professors and instructors will not know who was involved and what has been shared, especially when sharing about uncaring encounters in nursing education
- Explain research process in general terms including dissemination (amalgamation of data with all identifiers removed)
- Let them know this will not affect their grades or status as a nursing student
- Ease any anxiety related to my role as a nurse educator
- Let them know they can stop at any time and choose not to answer any question(s)
- Let them know there are no wrong answers
- Explain to them what to expect during the interview process
- Be aware of my body language and vocal inflections
- Use communication techniques such as empathic highlights, active listening, probing, and summarizing
- Authentic presence
- Let participants lead the conversation; focus on what is important to them
- Respond to emails promptly with an appreciative and individualized approach
- Be open to meeting times that fit the participants schedule

Balancing the research context: Considering the parts and whole. Part of this research activity was concerned with the research plan as a whole, while considering each part of that plan, and coincides with van Manen's (1997) research activity six. Important parts of the research plan that were considered individually and within the greater context of the research included the setting, the sample, trustworthiness of the research, and ethical considerations.

Setting. The institutional setting was an Atlantic Canadian university. An important contextual consideration within the educational setting of interest is the curriculum. Given that learning caring is the central focus of this study, it is important to note and consider that the FON at the university of interest is guided by a curriculum that identifies caring as a philosophical underpinning, core value, and a type of relationship. Given this important contextual factor, curriculum documents were included as data. Curriculum documents were analyzed for the presence or absence of caring language. Curriculum documents included in this study are outlined in this chapter (see Table 1) and analysis of curriculum documents is discussed in chapter four (Findings).

Sample. As noted, the population of interest for this study was nursing students enrolled in a four year BN program. Inclusion criteria for participants included an ability to speak English and be enrolled in the fourth year of the bachelor of nursing program at the university of interest. This population was chosen based on the assumption that the student participants have experienced the phenomenon learning caring in their nursing education experience. This assumption is based on them completing at least three years of a nursing education program that identifies caring as a philosophical underpinning, core value, and a type of relationship. Although the

proposed sample size was three to five participants the final sample was two participants.

In determining sample size, van Manen explained that data saturation is not a goal of phenomenological inquiry; going so far to say *...saturating the data does not make sense when doing phenomenology* (van Manen, Higgins, & van der Riet, 2016, p. 4). He explained that the data cannot be saturated; there is always something new to learn. Instead of focusing on the number of participants, a number of scholars have suggested that decisions related to sample size ought to depend on important epistemic, methodological, and practical considerations (Baker & Edwards, 2012).

Given the important nature of caring in nursing education, understanding the lived experience of learning caring has great relevance to the community of nurses and nurse educators. There is minimal literature that specifically explores the lived experiences for nursing students of learning caring in a nursing education curriculum that has caring as a core value. As outlined in the background (Chapter 1) and literature review (Chapter 2) of this thesis, this study was important to further develop knowledge about nursing students lived experiences of learning caring .

Obtaining rich and thick research data about the lived experience, which is the goal of phenomenological inquiry, is determined by the quality of questions and prompts used during the interview (van Manen, 1997). The development of the interview guide is described further in this chapter in the section, data collection interviews. The original and revised interview guides are included as appendices (Appendices C & D). According to van Man (1997), the essence or meaning of the lived experience is central to phenomenological research; therefore, every lived experience is valuable to interpret meaning. Although the final sample was smaller than the proposed sample, Passerini

and Sandino (as cited in Baker & Edwards, 2012) have suggested that one qualitative interview can provide a rich expression of the participant's experience or subjectivity. Because of the richness of the data gathered from this study, the research supervisor deemed that a sample of two participants was sufficient.

Practical factors such as funding and timeline were also considered when determining the sample size for this study. This study was not funded by an outside source and I was responsible for all costs incurred which amounted to approximately \$100. This included travel costs, cost of a chocolate treat for each participant, and the \$50 grocery store gift card incentive.

When deciding on a sample size the research timeline was another practical consideration. The proposed timeline for this study is outlined in Appendix E and the revised timeline is outlined in Appendix F. Given challenges with recruitment and following dialogue and agreement with thesis committee members, a smaller sample size aided in the successful completion of this project within a reasonable timeline.

Trustworthiness. Trustworthiness of a study is enhanced if an independent party or the reader can audit the study and account for the events, influences, and actions of the researcher (Koch, 2006). While there is no one agreed upon method for promoting and confirming the trustworthiness of qualitative research, the concepts of credibility, transferability, dependability, and confirmability are commonly cited (Lincoln & Guba, 1985; Polit, Beck, Loiselle & Profetto-McGrath, 2011). Credibility is the degree of truth that can be assumed from the collected data (Lincoln & Guba, 1985; Polit et al., 2011) and to which the findings can be believed or trusted by participants (Petty, Thomson, & Stew, 2012). Transferability is the extent that the findings can be applied to similar settings or contexts (Lincoln & Guba, 1985; Polit et al., 2011). Dependability is the

stability of the data over time and conditions (Polit et al., 2011, p. 269). Confirmability is the extent to which a study can be replicated or reproduced by two or more independent parties (Lincoln & Guba, 1985; Polit et al., 2011) and is the product of the inquiry and not the bias of the researcher (Petty, Thomson, & Stew, 2012). Below is a discussion of each element of trustworthiness and how it relates to this study.

The credibility of this study was promoted through persistent observation, openness to disconfirming evidence, and member check interviews (Polit et al., 2011). Persistent observation involved maintaining a strong pedagogical orientation to the phenomenon of learning caring. This orientation is described in detail earlier in the section, maintaining a pedagogical orientation to the phenomenon. Also, the researcher's persistent observation of self is important. I have discussed in detail my foreknowledge and experience with the phenomenon of interest and throughout the research process I continued to document and consider how this prior knowledge and experience might impact data analysis. To continue the process of persistent observation and orientation towards the student participants, I maintained a reflective research journal in which I recorded my observations before and after each interview (Koch, 2006). Reflections are discussed throughout this chapter. Another component of the reflective journal was detailed methodological notes that described all decisions made including rationale for decisions and conclusions. See Appendix B for the reflective journal guide.

Another means to promote credibility is by being open to disconfirming evidence throughout data collection and analysis. This involved me (the researcher) being open to evidence that participants did not value caring, did not learn caring in nursing education, or that nursing education somehow limited their learning caring.

Another way to promote credibility is through member checks, which are an important component of phenomenological human research (Doody & Noonan, 2013; van Manen, 1997). Member check interviews occur through second interviews with participants (Lincoln & Guba, 1985; Polit et al., 2011). One member check interview was conducted for this study. During the member check interview, descriptions and interpretations of the data were shared with the participant through a recorded conversation about the findings of this study. Data was shared section by section; then, after each section, the participant was asked questions such as:

- What about this represents your lived experience of caring?
- What about this doesn't represent your lived experience of caring?
- What about this represents your lived experience of learning caring?
- What about this doesn't represent your lived experience of learning caring?
- What would you like to add?

The process of member checking helped ensure data analysis was representative of the participant's lived experience (Curtin & Fossey, 2007).

Transferability refers to the research context (Koch, 2006). To ensure the data was transferable, the research context is described in detail in chapter four (Findings), in which a thick description and interpretation of the phenomenon is presented within the context of the curriculum of interest. A thick description provides enough detail so that the meaning and context of the phenomenon can be determined by the reader (Curtin & Fossey, 2007). Given the important nature of writing and rewriting in van Manen's (1997) research approach, a thick description is an expected result of data analysis as is writing occurring concomitantly with data collection. To further promote transferability,

curriculum documents, which provided valuable context for the phenomenon, were analyzed concomitantly with interview data. The entire process supported transferability.

Dependability was enhanced as thesis supervisors got to know the data collected and ensured my analysis and conclusions were representative of the data. This form of researcher triangulation (Curtin & Fossey, 2007) or peer checking (Rolfe, 2006) ensured congruence in data analysis. Using this approach, which is often referred to as researcher triangulation, involves having two or more researchers analyze data and examine findings so that single researcher bias is minimized (Curtin & Fossey, 2007). Rolfe (2006) identified peer checking as more experienced researchers analyzing all or a portion of the data to ensure the same or similar conclusions were identified. Researcher triangulation and peer checking occurred naturally as I (the graduate student researcher) engaged in collaboration with my research supervisor and committee member (experienced researchers) to analyze the data. Dependability can be jeopardized if data collection and analysis occurs over a long period of time (Graneheim & Lundman, 2004). To ensure I (the researcher) was held accountable to conduct the research in a timely manner, a research timeline was proposed in Appendix E with a revised timeline in Appendix F. Changes in the proposed timeline were due to delays related to ethics approval, the time required to engage in consultation with faculty members before gaining entry to the study site, and challenges with recruitment. Dependability is also strengthened by confirmability of the study.

Confirmability is promoted when dependability, transferability, and credibility are confirmed (Lincoln & Guba, 1985). For this study confirmability was promoted through reflexivity, which was made explicit in a reflective journal (Curtin & Fossey,

2007). As decisions and conclusions were made, a journal entry with rationale was made. Journal entries were also completed before and after each participant interview. Within the reflective journal, an audit trail was maintained through field notes, reflective, and methodological notes. The reflective journal supplemented interview and curriculum data. The reflective journal, interview, and curriculum data will ensure an independent party can audit the study and confirm the data analysis and conclusions.

Ethical Considerations. Ethical considerations included my role as a nurse educator, voluntary participation, risks and benefits, incentives, and confidentiality.

My role as a nurse educator. To minimize ethical concerns related to my role as a nurse educator, I collected data from students on a campus separate from the campus at which I worked as a nurse educator. This ensured students did not feel pressured to engage in the research based on my role as a past, present, or future nursing instructor.

Voluntary participation. Participants were made aware that participation in this research is entirely voluntary. Participants were also made aware that the choice to participate or not participate would not impact their grades or status as a nursing student. Without any penalty, the participants could at any time change their minds and stop participating in the study even if they agreed earlier to participate. An important component of voluntary participation is informed consent; therefore an informed consent information sheet (letter of information) and informed consent certificate was given to potential participants (Appendix G). I ensured participants had ample opportunity to consider and understand the implications of participating in the research. Students were encouraged to ask clarifying questions related to the study and their involvement through face-to-face and/or email communications. Participants were encouraged to ask questions. In addition, prior to the interview starting and before the participant signed

the informed consent form, I reviewed the information sheet with participants and they were given an opportunity to ask questions or seek further clarification regarding their understanding of the research study and the consent form.

Risks and benefits. There were no anticipated risks related to taking part in this research. However, at the beginning of the interview, participants were made aware that they could request that the interview stop and/or they could choose not to answer a particular question or questions at any time for any reason. The benefit of being involved in this research for students was an opportunity to share their learning experience and debrief and reflect on their experience of learning caring. Students may have also benefited from an opportunity to learn more about the qualitative research process, by being an integral part of the project.

Incentives. In an effort to honor participants' time and commitment to this research project, participants had their name entered in a draw to win a \$50 grocery store gift card. Ballots were entered into the draw as *Interview 1* and *Interview 2*, then a neutral party, with eyes closed, chose a ballot from a hat. I contacted the winner via email. At the completion of each interview participants were also given a chocolate treat. A thank you note was sent to each participant. The thank you note was intended to thank students for their participation and share with them how engaging in research promotes their meeting the entry to practice competencies set forth by our provincial regulatory body (NANB, 2013) (see Appendix H for the thank you note).

Confidentiality. It is up to participants to decide whether or not they share their experience about participating in this research with others. To promote confidentiality, no information about the participants or their involvement in the research was shared with anyone outside of the research team. The information that I collected from this

research project was and will continue to be kept private and confidential. Consent forms have been kept in a locked cabinet in my (student researcher) office as evidence of free and informed consent. Recorded interviews were transcribed verbatim into a written electronic copy with all names, places, and other identifying information removed. Participant names were replaced with pseudonyms chosen by participants. Only I (the researcher) know the participants' pseudonyms. I have not and will not release publicly any personal information that might identify participants. This includes information such as birthdates, hometowns, or other people and places related to participants' experiences; these potentially identifying details have not been included in written transcripts. When quotes are included in research reports, publications, or presentations, I paid careful attention to ensure that contextual indicators that could identify participants are not included. All printed interview transcripts will be stored in a secure locked cabinet in my (the researcher's) office for five years after the study is completed; after this time, I will destroy the information. Electronic transcript files will be kept for a maximum of seven years for potential secondary analysis.

The knowledge gained from this research has been and will be shared with participants and interested faculty members from the faculty of interest before it is made widely available to the public. Each participant will be offered a copy of the completed thesis findings. Research results will be submitted for publication so that other interested people may learn from this research.

Data collection (investigating the lived experience). Investigating the lived experience of learning caring, instead of the conceptualized experience of learning caring for nursing students, requires a strong orientation to the meaning of learning caring. This coincides with van Manen's (1997) research activity two in which van

Manen (1997) posited that to investigate the lived experience, the researcher must start with their own lived experience. My own lived experience related to learning caring has been described in detail above in the section, turning to a phenomenon of interest.

Another way to investigate the lived experience is to explore the etymological sources and idiomatic phrases of the phenomenon (van Manen, 1997). Without this exploration, words used to describe a phenomenon can seem hollow or without meaning. van Manen (1997) used the example of caring. He questioned the overuse of the word caring and whether or not its true meaning is understood. For this study, exploring and describing the origins of caring in general terms and more specifically in nursing education is very important to understanding the lived experience of learning caring for nursing students. For this purpose, a background discussion about caring in nursing and nursing education is provided in Chapter one (Background and Significance). More specifically a literature review was conducted to gain an in-depth understanding of previous research related to nursing students' lived experiences of learning caring. The literature review is presented previously in Chapter two (Literature Review).

In addition to turning to one's own experience and exploring etymological sources of the phenomenon, obtaining experiential accounts from others is a cornerstone to investigating the lived experience. Obtaining this data from others is an important means of investigating the lived experience. Through data collection, researchers explore the experiences and reflections of others in order to gain a deeper understanding of the phenomenon. The goal of collecting data in phenomenological research is to answer the question, *what is the nature of this phenomenon as an essentially human experience?* (van Manen, 1997, p. 62). To achieve this goal, a number of data collection approaches including written descriptions of lived experiences; conversations;

observations; biographies, diaries, journals, logs, art, and other phenomenological literature can be employed (Converse, 2012; van Manen, 1997). Data for this study included curriculum documents, interview data, and pre and post interview reflections. Prior to accessing curriculum documents and initiating interviews I sought and received ethical approval (UNB REB #2017-123) and sought and obtained permission to use curriculum documents as data. The original email sent to the FON of interest is available in Appendix I. I was also provided with names of faculty members who were working with fourth year nursing students.

Recruitment strategies. After receiving ethics approval (UNB REB # 2017-123) from two committees at the university (Faculty of Nursing [FON] and Research Ethics Board [REB]), recruitment began late in the 2017 fall academic term. Recruitment strategies for this study included both passive and active methods. Passive recruitment involved using different means, for example posters and advertisements, to attract potential participants to enroll in the study (Gelinas et al., 2017). A passive recruitment strategy for this study included placing recruitment posters (Appendix J) with business cards (Appendix K) in high student traffic areas. In early December 2017 I visited the recruitment site. Six posters were placed around the department. Locations included the stairwell, the main lobby, the fourth year dedicated cork board, the door of a fourth year professor, and one in each the women's and men's washrooms. The poster included details related to the research question, inclusion criteria for participants, incentives, and contact details for the graduate student researcher and research supervisor (see Appendix J).

Another passive method of recruitment involved accessing potential participants through the university webpage. To do this, I posted details of the study on the news

and events section of the university webpage. Details included in the notice were the same as those included on the recruitment poster. Word of mouth or the snowball method of recruitment (Converse, 2012) was also used as a passive recruitment method. To recruit using this method I mentioned my study to all nursing students and nursing faculty members whom I came in contact with as a nurse educator and graduate student.

In addition to passive recruitment strategies, active recruitment strategies, which involved the researcher intentionally seeking out potential participants in an effort to share the research project with them and enroll them in the study (Gelinias et al., 2017), were used. Active strategies included sharing the recruitment poster with potential participants via a targeted email to all fourth year students (55 total), posting a message on the electronic learning management system for a fourth year course, having the course professor make an in-class announcement, and the researcher visiting the class and making an announcement about the study.

An active recruitment strategy included sharing the recruitment poster through targeted electronic means for example using the social media website, Facebook. Facebook has shown promise in recruiting research participants including populations that are considered hard to reach (Gelinias, et. al., 2017). Facebook has also been used successfully to recruit research participants who are 16-24 years old; for example 50% of participants (n=4) in one study were recruited using Facebook (James, Taylor, & Francis, 2014). Given that the approximate age of participants for this study was about 22-24 years of age, Facebook was used as a recruitment method. This involved posting the recruitment poster and a brief message about the study on the fourth year nursing students' Facebook page.

All participants and one potential participant contacted me within 24 hours of the face-to-face classroom recruitment visit. One participant noted that the face-to-face visit was the most helpful recruitment method because they valued hearing about the study in person and having an opportunity to ask questions. The same participant explained that research emails and posters are often ignored or deleted because of the large quantity they see and receive.

It is important to note that at the time of recruitment, in addition to a three credit hour online course, the potential participants were enrolled in their final nursing practicum, which occurs over a 12 week period and consists of full time hours working/learning with a registered nurse. This recruitment period was less than ideal in terms of potential participant availability. In order to recruit more potential participants, in winter 2018, my recruitment message and poster was re-shared on the fourth year Facebook page. In addition, my recruitment message and poster were shared with the class list via an electronic learning management system. I did not receive any indication of interest from further potential participants.

Data collection interviews. As soon as participants were available, interviews began. For the purpose of this study, face-to-face conversational interviewing was the method of choice for data collection. With each participant, there was one interview. A second interview to member check the data was conducted with one participant. Like the first interview, the member check interview was recorded and lasted approximately one hour and 15 minutes. Participants chose interview spaces that were comfortable for both parties. By offering to meet with participants in a space of their choice participants were in control of their exposure to the public.

The goal of the first interview was to answer the research question, “What is it like for BN students in a four year program to learn caring within a curriculum that has caring as a core value? The goal of the member check interview was to engage in member checking, that is to determine whether or not the participants feels their experience is accurately represented in the research findings.

Recorded, in-depth, one-on-one interviews were conducted to explore the nursing students’ lived experiences of learning caring. Two interviews were conducted in January 2018 with participants Martha (pseudonym) and Anne (pseudonym). A semi-structured interview guide (Appendix C) was used to help guide Martha to recall their experience of learning caring. The interview guide was not exhaustive. As interviews progressed, from interview one with Martha to interview two with Anne, new prompts were developed to further explore and understand the participant’s experience. A revised interview guide was used with the second participant, Anne (Appendix D)

Two prompts were added to the interview guide based on what was learned in the first participant interview. The first additional prompt was related to what made the participant want to participate in the study including what recruitment strategy caught their attention. This prompt was added to gain insight into the participant’s motives for taking part in the study while also gleaning valuable data about successful recruitment methods. The second prompt was related to specific courses in which caring was talked about and/or learned in a direct way. This question was added as a means to glean data about whether or not participants could recall specific courses in which caring was addressed or learned in very direct or explicit manner (e.g. making a direct connection between course content and caring).

Each interview began with the participant and me (the researcher) reviewing the letter of information (information sheet) and signing the informed consent certificate (Appendix G). Once the consent form was signed, I began the interview by starting the digital recorder and moving through the prompts as outlined on the interview guide. Clarifying prompts were added as needed throughout each interview. The interviews passed through three stages, which were: establishing the context of the participant's experience, constructing the experience, and reflecting on the meaning of the experience for the participant (Flood, 2010). Each participant shared a unique meaning of the lived experience of learning caring that aided in the description and interpretation of what it means to learn caring. Through gathering the lived experiences, a deeper understanding of what it was like for nursing students to learn caring was gleaned. The phenomenological themes that arose from the interview data will be discussed in Chapter four (Findings).

To ensure interviews were oriented toward the participants' lived experiences of learning caring, the phenomenon of interest; van Manen (1997) asserted that the researcher must consider other questions, in addition to the interview questions, during data collection. Specific questions for this research study that were part of the post interview reflection included:

- How does this student's experience represent learning caring?
- What has it been like for this student to learn caring?
- What is the meaning of learning caring for this student?

In addition to answering the above three questions, journal entries were used to capture my thoughts, decisions, and conclusions and describe each participant's

demeanor and body language. Describing and reflecting on participants' demeanor and body language in the journal entries was a helpful approach to capture communication that was not available through digital audio recording.

Data collection curriculum documents. In addition to interview data, data collection also included gaining access to curriculum documents. Ethical approval was obtained (UNB REB # 2017-123) and permission was sought and granted from the FON of interest to access curriculum documents. To provide important contextual data, curriculum documents, including historical and present documents, were collected and analyzed prior to and concomitantly with interview data. Curriculum documents were received via email and accessed via a digital learning management system. Curriculum documents accessed and analyzed for this study are outlined below in Table 1 in this chapter. Curriculum documents from this study provided important context to the participants' lived experiences of learning caring.

The curriculum is important to the lived experience of nursing students. Therefore curriculum analysis is necessary to understand the participants' experiences within the nursing education program. In New Brunswick, schools of nursing are held accountable to two sets of standards including those from the Nurses Association of New Brunswick (2015) and those from the Canadian Association of Schools of Nursing (CASN) (2014). For both NANB (2015) and CASN (2014), a paramount component to program approval and accreditation is systematic and ongoing assessment and development of the curriculum. According to the accreditation program standards for nursing programs, a program is accredited based on standards including those related to the educational unit and those related to the nursing education program (CASN, 2014). The nursing education program refers to the curriculum including ongoing curriculum

evaluation. A key element of the CASN (2014) accreditation standards is that faculty implement the nursing education program in a way that reflects its philosophy and the formal curriculum model and plan (CASN, 2014). To support this key element, curriculum documents, need to clearly and accurately articulate the curriculum philosophy and curriculum model and plan. Brown (2011) suggested that the design of nursing curricula should be guided by caring values and caring as a core value should be threaded throughout the nursing curricula. In particular, to help nursing students internalize caring behaviours, Brown (2011) suggested that strategies be mapped throughout curricula in a hierarchical design. Another key element is a clear and logical sequence of learning opportunities and experiences for students as they move through the program. The opportunities and experiences should *...capture current and emerging trends and include appropriate learning processes (pedagogy)* (CASN, 2014, p. 23). In addition to CASN (2014), NANB (2015) has set out indicators for approval. CASN requires that the philosophy of teaching and learning in the curriculum be current, evidence based, and relevant to nursing. To ensure ongoing development of the curriculum, CASN suggests there should also be key stakeholders, such as patients, nurses, and nursing students, who carry out systematic and continuous evaluation of all curriculum components. NANB (2015) suggests that curricula stay current by responding to emerging trends in health care, nursing practice, and nursing education. Given that nursing students are engaged in the lived experience of nursing education curricula, it is important to know more about the lived experiences of nursing students including how they learn caring within the context of particular curriculum design and implementation. Following is a discussion about how knowledge was gleaned from this study through data analysis according to van Manen (1997).

Data analysis. The purpose of this study was to grasp the essential meaning of what it is like for bachelor of nursing students, in a four year program, to learn caring in a curriculum that has caring as a core value. Data analysis was conducted using van Manen's (1997) phenomenological research method, which consists of six research activities. Each activity was discussed in more detail earlier in this chapter. According to van Manen's (1997) research method, data analysis occurs within research activities three and four. Research activity three, reflecting on the essential themes, and research activity four, writing and rewriting, are intended to aid the researcher to *grasp the essential meaning of something* (van Manen, 1997, p. 77).

Writing is integral to phenomenological research, spanning the entire process (Converse, 2012). *Creating a phenomenological text is the object of the [human science] research process* (van Manen, 1997, p. 111). van Manen (1997) asserted that writing is not an afterthought, but rather the method of phenomenological human science. Through written language one can become acquainted with the world (van Manen, 1997). Writing can put into words, the silence often experienced with language. van Manen (1997) explained that the taken for granted within our worlds lives in silence and, for that reason, silence makes phenomenological human research possible and necessary. In an effort to stay true to van Manen's (1997) research method, including the critical nature of writing, I engaged in writing during all stages of data analysis. For example, when reading through curriculum documents I developed a journal entry for each document including a description of the document and my thoughts about each document. When analyzing interview data I engaged in six stages of interview analysis in which reading and writing were integral. The processes of reading and writing are described in more detail later in this section.

Data analysis through reading, re-reading, writing, and re-writing was conducted to facilitate the identification of phenomenological themes and the creation of a phenomenological text (van Manen, 1997). Phenomenological themes are best understood as structures of experiences; essential components that make up the lived experience of a phenomenon (Reiners, 2012; van Manen, 1997). Phenomenological themes help to describe and interpret the meaning of the lived experience.

To identify phenomenological themes, thematic analysis was employed, which is a *free act of 'seeing' meaning* (van Manen, 1997, p. 79) within the lived experience data. To conduct selective thematic analysis, as described by van Manen (1997), I read the transcribed verbatim interview data multiple times to answer the question, *What statement(s) or phrase(s) seem particularly essential or revealing about* (van Manen, 1997, p. 93) nursing students' experiences of learning caring? Once the statements or phrases were identified they were highlighted. In order to prepare for research activity four the highlighted themes were used to develop phenomenological notes and paragraphs. In an effort to determine the essential themes, I considered the question, *does this theme ...make the phenomenon what it is and without which the phenomenon could not be what it is* [?] (van Manen, 1997, p. 107). The process of identifying essential themes through reading, writing, and rewriting is discussed in more detail in the interview analysis section of this chapter. In addition to selective thematic analysis of interview transcripts, to provide important context related to participants' lived experiences of learning caring, curriculum documents were also analyzed for the presence and absence of caring.

Curriculum document analysis. Curriculum documents were analyzed prior to, during, and after participant interviews were conducted. As curriculum documents were

being analyzed, a question about more historical curriculum documents arose which resulted in my interest in inquiring about historical documents that describe the addition, integration, and/or evolution of caring in the curriculum at the FON of interest. A past Dean and a past curriculum committee member and chair person were contacted. The past Dean highlighted three resources that might provide details about the evolution of caring in the curriculum. The suggested resources included a document from 1995, which they authored, that explained the launch of the curriculum at that time – the document was not accessible. The past Dean also suggested the document entitled, *Reflections II FON 1983-2008*, which they also authored that described the evolution of the curriculum from 1983 to 2008. The *Reflections II* document was obtained through the present Dean’s office and is discussed in more detail in Table 1 and a subsequent section titled Curriculum document analysis. The third resource highlighted by the past Dean was the textbook, *Toward a Caring Curriculum: A New Pedagogy for Nursing*, by Em Bevis and Jean Watson (1989). It was suggested that this text was used to inform the integration and evolution of caring in the curriculum. The Bevis and Watson (1989) text was not directly referenced in the curriculum documents in terms of caring. It was used to support praxis and for that reason, the Bevis and Watson (1989) text was not analyzed in terms of literature used to support caring in the curriculum.

The past FON curriculum committee chairperson also highlighted three resources. The first was a document from 2009 that outlined the curriculum shift from a competencies based curriculum to an abilities and outcomes based curriculum. This document is titled *FON Overview (2009)* and is discussed in more detail in Table 1 and in this section. The second resource highlighted by the past curriculum committee chair was the Nurses Association of New Brunswick (NANB) (2013) *Entry Level*

Competencies for Registered Nurses in New Brunswick. This document was used in the mid 2000's to inform the shift towards an abilities based curriculum; however it was not cited when describing caring in the curriculum documents therefore it was not included in this analysis. The third resource included the approval and accreditation documents in which, the curriculum committee chair suggested, caring as a philosophical underpinning should be described and supported. The approval and accreditation documents were requested from the FON, however permission was not granted to access the documents therefore they were not included in this analysis. Curriculum documents included in the analysis are outlined below in Table 1 and subsequent paragraphs of this section. Given some difficulties in accessing historical documents that outline and/or describe the integration, addition, and/or evolution of caring in the curriculum a need exists to archive curriculum documents so they can be accessed to inform present day curriculum decisions and documents. This may lead to an increased emphasis on caring in the curriculum.

Table 1

Curriculum Documents Included in Analysis

Curriculum Documents (year[s])	Brief Description of each Curriculum Document	Presence or Absence of Caring	Research, Professional literature, & Textbooks used to Support Caring in Curriculum Documents (year)
Vision, Mission, and Values (Not identified)	Outlines the mission, vision, and values of the FON	Present	None identified
Putting Together the Big	Includes a visual diagram and written description of the FON curriculum including the	Present	<ul style="list-style-type: none"> • Bent (1999) • Dillon & Stines

Picture FON (2012)	philosophical underpinnings, nursing meta-paradigm concepts, nursing core concepts, and program abilities		(1996)	<ul style="list-style-type: none"> • Hanson & Smith (1996) • Leininger (1991) • CNA Code of Ethics (2008) • NANB Standards of Practice for Registered Nurses (2007) *2007 edition no longer available; revised in 2013 • Potter, Perry, Ross-Kerr, & Wood (2010)
BN program courses (2017)	Outlines the sequence of courses, including credit hours, throughout the 4 years of the BN program	Absent	Not applicable	
BN Program Abilities Leveled Outcomes (2009)	Outlines program abilities, BN program learning outcomes (unleveled), and learning outcomes (leveled) for each year of the program	Present	Not applicable	
Twenty seven BN course blueprints (2016-2017)	Each blueprint outlines the calendar description, purpose, and leveled learning outcomes for each nursing course	Present in 14 of 27	Not applicable	
Overview and Preamble of the FON Abilities Based Learning Framework and Architecture (2009)	Outlines a curriculum transition from a competencies based curriculum to an abilities and learning outcomes based curriculum	Absent	None identified	

Reflections II: FON 1983-2008 (2008)	Outlines the evolution of the BN program from 1983 to 2008	Present	None identified
History of the FON (Not identified)	Outlines the evolution of the FON program and curriculum from its inaugural class in 1958 to 2006	Absent	None identified
FON Curriculum Education Philosophy (Not identified)	Outlines the philosophy of education including the pedagogy of teaching and learning specific to the BN program	Absent	None identified

Note: BN=Bachelor of Nursing; FON=Faculty of Nursing; NANB=Nurses Association of New Brunswick; CNA=Canadian Nurses Association

Each curriculum document outlined in Table 1 was analyzed for the presence or absence of caring language. In addition to reading each document, a search was done using the search function on the electronic Microsoft Word or PDF form of each document. Caring was present in the *FON Vision, Mission, and Values* document, the *Putting Together the Big Picture FON* document, the *BN Program Abilities Leveled Outcomes* document, 14 out of the 27 course blueprints, and the *Reflections II: FON 1983-2008* publication. It was interesting to note that caring was not present in many of the current curriculum documents. When caring was present in a curriculum document, an analysis was conducted to determine the quantity and quality of literature used to support caring. Many forms of research literature, professional literature, and textbooks informed the curriculum documents; however literature to specifically support caring in the curriculum was minimal. Reference lists were not included with some curriculum documents, which made it challenging to access supporting literature. Each document is described including an analysis of the document in terms of the presence and absence of

caring and the process to access each document. The findings related to curriculum documents is described in detail in Chapter four (Findings). In addition to curriculum document analysis, interview analysis occurred and is discussed below.

Interview analysis. In addition to curriculum document analysis, verbatim interview transcripts were analyzed, both on their own and within the context of the curriculum documents. In order to identify phenomenological themes through reading, re-reading, writing, and rewriting, data analysis of interview transcripts was conducted in six stages. Each stage involved writing and reading the interview transcripts and curriculum documents, going back and forth between the data as a whole and its individual parts. Each stage of the interview analysis is outlined below.

Stage 1 interview analysis. Stage one of the interview analysis involved highlighting meaningful words, phrases, and statements from the verbatim interview transcripts. To ensure I (the researcher) remained open to findings beyond the aims of the study, I maintained an “extra thoughts” section for each interview. Analysis at stage one was handwritten and answered the question, *What statement(s) or phrase(s) seem particularly essential or revealing about* (van Manen, 1997, p. 93) nursing students’ experiences of learning caring? Four different coloured highlighters were used to identify data related to each study aim. These highlighted words, phrases, and statements were then used to create phenomenological text that helped to describe and interpret participants’ lived experiences of caring and learning caring. Printed transcripts with stage 1 analysis are stored in a locked filing cabinet.

Stage 2 interview analysis. Stage two of the interview analysis involved identifying and collating significant words, phrases, and statements that stood out in stage one of the interview analysis. This stage also involved looking for patterns and

overlaps within each individual interview (i.e. did the participant say the same thing at different points in the interview process?). This process involved reading and synthesizing stage one notes then rereading the verbatim interview transcripts to ensure the synthesis accurately represented the raw interview data. I continued to ask the questions *what statement(s) or phrase(s) seem particularly essential or revealing about* (van Manen, 1997, p. 93) nursing students' experiences of learning caring? and does this theme *...make the phenomenon what it is and without which the phenomenon could not be what it is* [?] (van Manen, 1997, p. 107). Stage 2 of the interview analysis consisted of electronic and hand written notes which are stored in a locked filing cabinet.

Stage 3 interview analysis. Stage three of the analysis consisted of creating stories based on each participants meaning of caring (Martha's Meaning of Caring; Anne's Meaning of Caring). This approach is consistent with the method of writing and rewriting according to van Manen (1997). Creating stories helped to present the data in narrative form while also providing an opportunity for me to reflect on participants' experiences through reading and writing to identify phenomenological themes. Phenomenological themes are presented in Chapter four (Findings). Each story was confirmed by referring back to the original interview data. Once each participant's story was created, a third story was created to capture the combined meaning of caring across both stories (Martha and Anne's combined meaning of caring). A fourth story that focused on the meaning of learning caring was created to capture participants' combined lived experience of the phenomenon learning caring (Martha and Anne's combined meaning of learning caring). This was done because participants' lived experiences of learning caring were very similar. There are a total of four stories that are presented below in Chapter four (Findings).

Stage 4 interview analysis. To identify phenomenological themes meaningful words, phrases, and statements identified in previous stages of the interview analysis were analyzed across participants' experiences. Stage four of the interview analysis involved comparing and synthesizing those meaningful words, phrases, and statements through reading, re-reading, writing, and rewriting. Phenomenological themes are presented in Table 8 and described in detail in Chapter four (Findings)

Stage 5 interview analysis. Stage five of the interview analysis involved analyzing the interview data within the context of the analyzed curriculum documents. Considering the lived experience within the context of the curriculum was an important step in interpreting the lived experience of learning caring. It was also a means to support and ensure trustworthiness. Trustworthiness is described in more detail earlier in this chapter. The findings from this stage of the interview analysis are outlined in Chapter four (Findings).

Stage 6 interview analysis. Stage six of the interview analysis involved rereading the phenomenological themes and comparing them to the original interview transcripts. When doing this, direct quotes were extracted from the interview transcripts and made part of the phenomenological text that describes and interprets the meaning of learning caring for participants of this study. In doing this I continued the process of reading, writing, reading, rewriting and balancing the parts of the research with the whole. Notes to enhance this stage of data analysis were maintained in the reflective journal. A detailed description of all findings related to curriculum document analysis and participant interview analysis is presented next in Chapter four (Findings)

Chapter 4: Findings

The findings from this study are based on analysis of curriculum documents and participant interviews. Each curriculum document was analyzed for the presence and absence of caring language and participants were interviewed to explore their lived experience of learning caring. Curriculum documents were analyzed individually, as a whole curriculum, and within the context of the interview data. Analysis of participant interviews occurred in six stages and included thematic analysis conducted, according to van Manen (1997) through reading and writing that resulted in the development of phenomenological stories and themes. To better understand the meaning of learning caring, phenomenological themes were analyzed within the context of the curriculum and participants' meaning of caring. Below are findings related to individual curriculum documents, curriculum documents as a whole, and six stages of participant interview analysis. Following are the findings related to individual curriculum documents conducted prior to participant interviews, starting with the *FON Vision, Mission, and Values* statement. To follow is the interview findings including a discussion of interview findings within the context of the curriculum.

FON Vision, Mission, and Values

A brief description of this document is provided in Table 1. The vision and mission of the BN program are clear and stated as a future goal and purpose, respectively. Within the *Vision, Mission, and Values* statement, caring as a principle is viewed as necessary to educate and prepare nurses to work within an evolving health care system. As demonstrated in this document, overarching statements and ideas are expected of a vision and mission statement. As the document becomes more specific, for example with value statements, one might expect details related to a caring

pedagogy. As part of this document, values are intended to provide faculty members with clear expectations on how to proceed in their daily work. Components of caring identified in this document that should be included in all interactions at all levels include dignity, compassion, respect, and fairness. In addition, identifying caring as a value is intended to act as a way to advance substantive knowledge for caring science as a core nursing value.

It is important to note that caring was identified in the *FON Vision, Mission, and Values* statement as a principle and a value. As part of the mission statement, caring is a principle means to ground education. As a value caring is written in the first person and reads: *We will demonstrate dignity, compassion, respect and fairness at all levels in our internal and external interactions and will advance substantive knowledge for caring science as a core nursing value.* Caring as a value is meant to guide faculty interactions, which is an important way to support a caring faculty. In this document, caring as a value, is described in terms of dignity, compassion, respect, and fairness; however, strategies are missing that help faculty implement the different components of caring into their practice as nurse educators. According to Gurley, Peters, Collins, and Fifolt (2015) value statements should be strategic and action oriented. Given that caring is an integral part of this curriculum, it would be helpful for value statements to provide specific actions and strategies that help faculty and students implement caring.

Putting Together the Big Picture – FON

A brief description of this document is provided in Table 1. This document will also be referred to as *The Big Picture* document. The *Big Picture* document provides a diagram that is helpful to visualize the curriculum as a whole. The *Big Picture* document from 2012 contained a note that stated the *Big Picture* diagram was to be

updated. A request was made for a more recent version of the *Big Picture* document, however a more recent document does not exist. In this document caring is identified as one of three philosophical underpinnings of the curriculum along with primary health care and social justice. As shown in Table 1 this curriculum document is the one document in which caring is supported by literature. Literature that supports caring in this document includes three research articles (Bent, 1999; Dillon & Stines, 1996; Hanson & Smith, 1996), one nursing theory (Leininger, 1991), two professional documents (Nurses Association of New Brunswick [NANB], 2007; CNA, 2008), and one text book (Potter et al., 2010)

Within *The Big Picture* document, caring as a philosophical underpinning is described according to Leininger's (1991) Theory of Transcultural Care as an essential and universal phenomenon to human development and survival; however a definition according to Leininger is not offered. Caring is also described as a moral imperative of nursing that is defined as a biophysical, psychosocial, spiritual, cognitive, (Leininger, 1991) and sociopolitical (Bent, 1999) phenomenon. In *The Big Picture* document, NANB (2007) and CNA (2008) are cited as part of the values and assumptions of caring. Upon analysis, even though they were cited to specifically support the professionalization of caring in nursing, neither professional document previously cited contained the word caring. Also, in this curriculum document, caring is identified as being dynamic, informed, and intentional and requires a connection between knowledge, skills, and values (Bent, 1999). The importance of nursing education is also highlighted in *The Big Picture* document. For example, within the document it is noted that nursing education can enhance, call forth, and inhibit caring (Dillon & Stines, 1996; Hanson & Smith, 1996). In the document it is emphasized that the absence or presence of role

models is critical to enhancing, calling forth, or inhibiting caring in nursing education (Dillon & Stines, 1996; Hanson & Smith, 1996).

The Big Picture document also identifies 12 core concepts of the FON curriculum. When analyzing *The Big Picture* document for the presence or absence of caring, caring was present in the descriptions of five of the 12 core concepts; however in the description of each concept there is minimal discussion about caring (approximately 1-2 sentences). The five concepts in which caring is present include population health, professionalization/professional sensibility, nursing therapeutics/healing, inquiry, and caring relationships. Caring is present in the following ways: The core concept population health is underpinned by the value and principle of caring, among other things, and fits with nurses' concern for primary health care, social justice, and caring. Caring is identified as a critical attribute of the core concept professionalization/professional sensibility. For the core concept nursing therapeutics/healing, a knowledge base of caring among other things is required. Inquiry, another core concept, is necessary to develop caring knowledge. The final core concept in which caring is present is caring relationships. Caring relationships are defined and described according to Potter et al. (2010). According to Potter et al. (2010) developing and maintaining caring relationships is a learned inter/intrapersonal skill that is essential for effective collaboration and healing. It requires connecting with people on many levels including psychological, cognitive, and physical levels and is defined by the nature, intent, and context of the relationship. Caring relationships are transformational and should be guided by an ethic of care. Critical attributes of a caring relationship include self awareness, growth of self and others, therapeutic use of self, collaboration

with members of the health care team, intent, and an interrelation with professional sensibility and therapeutic communication.

As mentioned previously, the curriculum of interest is an abilities based curriculum consisting of five program abilities, knowledge and its application, communication, critical thinking/skills of analysis, professional identity, and social justice/effective citizenship. Within *The Big Picture* document each program ability is outlined and described. Of the five abilities that guide the curriculum one contains the word caring as part of the description. As part of the description of social justice/effective citizenship, students become responsible global citizens by engaging the ethics of caring, among other things, in diverse contexts.

Literature used to support caring in *The Big Picture* document was also analyzed. All resources, except the Code of Ethics for Registered Nurses (2008) are outdated. For example the research literature is from the 1990's, which means it is approximately 20 years old. Professional literature, specifically the NANB Standards of Practice for Registered Nurses 2007 edition is no longer available; the standards were revised in 2013. In addition the textbook authored by Potter et al. (2010) is currently available in a newer edition. This means that *The Big Picture* document, a seminal curriculum document, is supported in large part by outdated literature. To support the notion of evidence based practice, which is so important in nursing, this document could be updated with more recent literature.

BN Program Courses

A brief description of this document is provided in Table 1. This document outlines the sequence of courses including credit hours in the four year BN program. Table 2 outlines the number of courses and credit hours in each year of the four year BN

program. It was noted that the word caring is not present in any course titles. There is a course in the first year of the BN program entitled, Professional Relationships (N1032) (see Table 7), that focuses on developing therapeutic relationships (and addresses caring in the therapeutic relationship). It is important to note that up until 2001, a course titled Caring Relationships was part of the first and second year curriculum of the BN program (as noted in the *Reflections II: FON 1983-2008* document). This changed in 2002 when the course was renamed Helping Relationships and moved to the third year of the curriculum. The reason for changing the title and sequence of the course was not noted in any curriculum documents. This finding is interesting for two reasons. First this was the only course in the program in which the word caring was present in the title. Second, it moved the course to later in the BN program. Developing and maintaining caring and/or helping relationships is a fundamental skill that should be introduced early in the BN program. As pointed out above, the course N1032 provides a beginning foundation of caring that could certainly be built upon throughout the BN program.

Table 2

Nursing Courses and Credit Hours Across All Years of the BN Program

	Year 1	Year 2	Year 3	Year 4	Total across all years
Nursing Courses	4	8	10	5	27
Credit Hours	12	27	32	26	97

BN Program Abilities Leveled Outcomes

A brief description of this document is provided in Table 1. It was noted that the *Program Abilities Leveled Outcomes* document was last edited in 2009. A request was made for a more recent version of this document. However, a more recent version does

not exist. This is an important finding because this document directly informs the development of course blueprints, which directly impact course designs and instructional methods within the BN program. This document contains the five BN program abilities, (1) knowledge and its application, (2) communication, (3) critical thinking/skills of analysis, (4) professional identity, and (5) social justice/effective citizenship, including unlevelled BN program outcomes for each ability. The document also contains BN program outcomes leveled across each year of the BN program. For example, the unlevelled program outcome 1.1 under the program ability knowledge and its application is leveled across each year using language that represents expected student development according to the year of the BN program. Tables 3, 4, and 5 capture the presence of each of the three philosophical underpinnings, (caring, primary health care, and social justice), as they appear in the document. In addition to reading the document, data was generated using a search tool on the electronic PDF document.

Table 3

Presence of Each Philosophical Underpinning in Unlevelled Program Outcomes in the BN Program Abilities Leveled Outcomes Document

	Knowledge and its application	Communi- cation	Critical thinking	Professional identity	Social Justice	Total Outcomes
Primary Health Care	Outcome 1.4	0	0	0	Outcome 5.2	2
Caring	0	Outcome 2.3	0	0	Outcome 5.2	2
Social Justice	0	0	0	0	Outcomes 5.2, 5.3, & 5.5	3

As you can see from Table 3, caring is present in two unlevelled program outcomes. Caring appears once as part of the program ability communication and once as part of the program ability social justice/effective citizenship. The presence of each underpinning in the *BN Program Abilities Levelled Outcomes* document is consistent across each program ability; however it is interesting to note that none of the underpinnings, including caring, appear as part of critical thinking and professional identity, two of the five BN program abilities. Given the importance of caring as a professional imperative of nursing, this finding might be a concern.

Table 4 outlines the presence of each philosophical underpinning as they appear in the Program Abilities Levelled Outcomes document in each year of the BN program. As you can see from Table 4 the total presence of each underpinning across all years is consistent with primary health care showing up seven times and caring and social justice showing up eight times each; however an imbalance exists when considering the presence of each underpinning in each year of the BN program. For example caring appears in levelled outcomes twice in the first year, four times in the second year, once in the third year, and once in the fourth year. Given the importance of caring in nursing, consideration of a more balanced integration of caring in learning outcomes across each year of the BN program is important. This way students can build on and integrate what they have learned from year to year. It was noted that, as the program progresses into year three and four, the presence of caring language is minimal. This may lead to omission of caring in the course blueprints and thus course designs and instructional methods in upper years.

Table 4

Presence of Each Philosophical Underpinning per year in the BN Program Abilities

Leveled Outcomes Document

	Year 1	Year 2	Year 3	Year 4	The total across all years
Primary Health Care	1	1	1	4	7
Caring	2	4	1	1	8
Social Justice	2	2	2	2	8

Table 5 presents the data in a slightly different way by outlining the presence of each philosophical underpinning as they appear in the leveled outcomes of the BN program abilities. The total number of outcomes that contain each of the philosophical underpinnings is consistent across the leveled outcomes of the five BN program abilities with primary health care appearing 10 times, caring 11 times, and social justice 12 times; however when each BN program ability is considered the distribution of each philosophical underpinning is disproportionate. For example caring appears in the leveled learning outcomes of knowledge and its application twice, communication four times, and social justice 5 times. Caring does not appear as part of leveled learning outcomes for critical thinking and professional identity. This is despite an emphasis on caring in the core concept, professional sensibility, included in *The Big Picture* document. Given the important nature of caring in the nursing profession, it is surprising to find that caring is not included in learning outcomes related to professional identity. This finding may cause concern because, as pointed out in *The Big Picture* document, developing a caring relationship is a complex nursing skill (Potter et al., 2010).

Table 5

Presence of Each Philosophical Underpinning in Leveled Learning Outcomes in the BN Program Abilities Leveled Outcomes Document

	Knowledge and its application	Communication	Critical thinking	Professional identity	Social Justice	Total Outcomes
Primary Health Care	4	0	0	0	6	10
Caring	2	4	0	0	5	11
Social Justice	0	0	0	0	12	12

Course Blueprints

There are 27 course blueprints that represent 27 courses or 97 credit hours of the four year BN program. Course blueprints are developed based on the *BN Program Abilities Leveled Outcomes* document described above. It is in course blueprints that the language of each learning outcome is altered to match the purpose of the course. The number of courses and credit hours across each year of the BN program are outlined in Table 2.

Each course has a course blueprint that outlines the university calendar description of the course, the purpose of the course, the five program abilities, and a number of course specific learning outcomes related to each of the abilities. Course abilities and outcomes as they appear on course blueprints are typically included in some way on each course syllabus. For that reason it is the abilities and outcomes language on course blueprints that directly guide course designs and instructional methods. To

understand more about the presence of caring in the learning outcomes as they appear in the course blueprints, in addition to reading each document, a search of each philosophical underpinning was conducted using the search function on the electronic documents. Table 6 outlines the number of times each philosophical underpinning appeared in the course blueprints in each year of the BN program.

Table 6

Presence of Each Philosophical Underpinning in Course Blueprints Across All Years in the BN Program

	Year 1	Year 2	Year 3	Year 4	The total across all years
Primary Health Care	5	5	7	1	18
Caring	4	9	3	1	17
Social Justice	8	14	16	9	47

As outlined in Table 6 the philosophical underpinning that appears most often in the BN program course blueprints is social justice. It appears approximately 2.5 times more than the other two philosophical underpinnings, caring and primary health care. Social justice appears most often in the learning outcomes of the second and third years of the BN program. Primary health care appears fairly evenly across the outcomes of years one through three and only once in the outcomes of year four. Caring appears most predominantly in year two of the BN program, which consists of eight of the 27 nursing courses, and 27 of 97 credit hours in the BN program. Caring appears least in year four with only one outcome in five courses and 26 credit hours, containing the word caring. These data reveal that there is an imbalance between philosophical underpinnings in how they appear in the abilities and outcomes language. An even

distribution or threading of each philosophical underpinning throughout the curriculum would be beneficial.

Table 7 outlines data related to the presence of the word caring in course calendar descriptions, purpose statements, and outcomes. The word caring appears once in a calendar description of a nursing course and does not appear in the purpose statements of nursing courses. The nursing course that contains caring in its description is entitled Professional Relationships (N1032) and it occurs in the first year of the program. Placement in the first year of the program is important to begin setting a foundation of caring for nursing students. In terms of program abilities and outcomes, caring appears three times in the outcomes of knowledge and its application, seven times in the outcomes of communication, most frequently in outcome 2.3, and six times in the outcomes of social justice, most frequently in outcome 5.2. Caring does not appear in the outcomes of critical thinking and professional identity. This is consistent with the *BN Program Abilities Leveled Outcomes* document, which makes sense given course blueprints are developed from this document. However, as mentioned above, this is not consistent with *The Big Picture* document. In *The Big Picture* document, caring is a part of some curriculum core concepts including professional sensibility and inquiry, which seem to line up with the program abilities, professional identity and critical thinking.

It is important to note that the wording of each outcome changes across course blueprints. For example outcome 2.3 in one course may be different from outcome 2.3 in another course. The outcomes are leveled based on the year in the program and are made specific to each course.

Table 7

Outcomes and Courses in which Caring is Present in Course Blueprints

	Year 1	Year 2	Year 3	Year 4	Total number of outcomes containing caring (by ability)	Total number of courses containing caring
Calendar description	N1032	None	None	None	Not applicable	1
Course Purpose	None	None	None	None	Not applicable	None
Knowledge and its application	1.1 (N1032)	1.1 (N2063) 1.3 (N2145)	None	None	2	3
Communication	None	2.3 (N2189, N2063, N2041, N2157)	2.3 (N3033, N3073)	2.3 (N4322)	1	7
Critical thinking/Skills of analysis	None	None	None	None	None	None
Professional Identity	None	None	None	None	None	None
Social Justice/Effective Citizenship	5.2 (N1235, N1225)	5.1 (N2145, N2135) 5.2 (N2177)	5.2 (N3081)	None	2	6
Total number of outcomes containing caring (by year)	2	4	2	1		
Total number of courses containing caring (by year)	3	7	3	1		

Overview and Preamble of the FON Abilities Based Learning Framework and Architecture

A brief description of this document is outlined Table 1. This document describes a curriculum shift that occurred in 2009 in which the curriculum became abilities and learning outcomes based. Prior to 2009 the curriculum was a competencies based curriculum in which competencies were organized under three areas of nursing practice including being, knowing, and doing. The meaning of key terms such as abilities and outcomes are outlined in this document. Within the document a philosophical shift at a professional level is highlighted and explained, including how the shift affected the curriculum. It is important to note that caring is not mentioned in the evolution of the curriculum from a competencies based curriculum to an abilities and outcomes based curriculum except to say that the curriculum will continue to honour its commitment to the curriculum philosophical underpinnings which are primary health care, caring, and social justice.

Reflections II: FON 1983-2008

The *Reflections II* document is not an official curriculum document; however it outlines the evolution and nature of the BN program curriculum from 1983 to 2008. This document built on a previous document, *Reflections*, that outlined the nature of the BN program curriculum from the previous 25 years. Within the *Reflections II* document, among other topics, a continuing commitment to primary health care, social justice, and caring is highlighted. In this document, caring is defined in the same way it is defined in *The Big Picture* document; however citations supporting content related to caring are not provided. As mentioned previously, this publication highlights an

important change in course title and sequencing as it relates to a course previously titled Caring Relationships.

History of the FON

A brief description of this document is outlined in Table 1. This document outlines a historical shift in nursing education in which an undergraduate level degree was required as an entry to registered nursing practice. Within the document, the UNB FON's acceptance into the CNA as a recognized BN program is also described. The growth of the faculty as it came to include many campuses, including the campus where the students in this study completed their BN education, is also detailed. The philosophical underpinnings, including caring, are not mentioned in this document. Inquiry about whether a similar document exists related to the history of caring in the curriculum revealed that there is no such document.

FON Curriculum Education Philosophy

A brief description of this document is outlined in Table 1. This document outlines the pedagogical philosophy that guides the FON curriculum including how that pedagogy is lived in relationships between faculty members and nursing students. It is highlighted that nursing education is not only about class content, but also about the process of teaching and learning. The seminal text book, *Toward a Caring Curriculum: A New Pedagogy for Nursing*, by Em Bevis and Jean Watson (1989) is referenced a number of times in this document to support the pedagogy of the FON. It is interesting to note that the word caring is not included in this document. Instead the textbook is used as a source to support praxis. This seems to be a missed opportunity in terms of directly integrating caring into the curriculum.

When analyzing the curriculum documents as a whole many interesting findings were noted. Overall, caring is absent in most of the curriculum documents (see Table 1). When caring is present there are some findings to pay attention to. For example, when compared to the other philosophical underpinnings (i.e. primary health care and social justice) caring appeared much more throughout *The Big Picture* and the *FON Vision, Mission, and Values* documents which is promising; however caring appears much less and more inconsistently in the *BN Program Abilities and Leveled Outcomes* document and course blueprints. It was found that *The Big Picture* document contained caring 27 times, primary health care 11 times, and social justice 12 times. The *FON Vision, Mission, and Values* document contained caring three times, primary health care one time, and social justice one time. The presence of caring language diminishes as you move away from the philosophical underpinnings in *The Big Picture* document and move towards the program abilities and outcomes. This can perpetuate a gap between the theoretical component of caring and the lived experience of caring and learning caring in nursing education. In addition, it is important to note that the three philosophical underpinnings, primary health care, social justice, and caring, are identified as principles in the *FON Vision, Mission, and Values* document and as both philosophical underpinnings and philosophical foundations in *The Big Picture* document. Inconsistency in language used to describe these terms may perpetuate a misunderstanding of the meaning of the terms within the curriculum. Consistency in language used to identify primary health care, social justice, and caring is important to make clear the meaning of the concepts.

It was also interesting to note that all course blueprints have been updated within the last two years. This is a positive and important finding because it suggests that the

documents are kept up to date. Given that course blueprints are, in large part, informed by *The Big Picture* document and *BN Program Abilities Leveled Outcomes* document, it is possible that changes are being made to present curriculum documents, those that directly guide BN course design and instructional methods, based on outdated seminal curriculum documents. Also, given that caring appears much less in more recent curriculum documents, such as the course blueprints, when compared to older, seminal curriculum documents, such as *The Big Picture* document and the *Program Abilities Leveled Outcomes* document, one might wonder whether or not seminal curriculum documents are considered when updating more recent curriculum documents.

In addition to curriculum document analysis, participants' lived experiences were explored through one on one interviews with fourth year nursing students in a curriculum that has caring as a core value. Participants were Martha and Anne. Below is phenomenological text in which the meaning of caring individually and combined for Martha and Anne is described and interpreted. Then a combined meaning of learning caring for Martha and Anne is outlined. A definition of caring is offered and finally the meaning of learning caring for participants in this study is presented in two phenomenological themes that each contain subthemes.

Martha's Meaning of Caring

Martha values caring. For Martha caring meant many things. Prior to nursing Martha's meaning of caring was tender care and compassion received when sick from their parents. Also prior to nursing, caring was tasks such as medication administration, completed by nurses with hospitalized family members. Once in the first year of nursing, Martha's meaning of caring grew to include preserving dignity, privacy, and respect. As time progressed, Martha's meaning of caring became deeper; changing over

time and from patient to patient. Martha noticed her meaning of caring was changing, transforming. Caring could mean different things depending on patient needs. The transformation occurred as Martha spent more time in the BN program. Martha became aware of her transformation in the last year of the program when she was faced with more complex patients that required she reflect back and draw from previous learning. As Martha's meaning of caring transformed. Caring came to mean taking time to be with patients', to discover and respond to patient's needs, and to view and act on the holistic picture of the patient's story. Caring was also juxtaposed by uncaring. For Martha, uncaring meant disrespect and a lack of support from nurses and nurse educators towards patients and nursing students. Although time facilitated the experience of learning caring, time also perpetuated uncaring. Martha thought this was due to a generational difference. Martha described differences in caring among those nurses educated in previous years when the meaning of caring in nursing may have been different. Although hesitant, Martha provided two examples of uncaring. The examples included a registered nurse talking over a patient instead of talking with a patient and a nurse educator whose approach to teaching left students feeling disrespected and unsupported in their learning.

Anne's Meaning of Caring.

For Anne, *caring is at the top and everything else kind of falls around it.* Anne believes everyone deserves caring. Prior to nursing, caring for Anne was informed by family values and experiences with friends and family. Anne's family was *full* and present. A full and present family for Anne meant having a sibling and parents who are still together plus close relationships with extended family such as aunts, uncles, and cousins. Friends dubbed Anne a helper; friends went to Anne for comfort and support

when facing challenges. As Anne progressed in the BN program, her meaning of caring evolved to be more in depth and holistic. Caring came to mean more than the tasks of nursing (i.e. caring as a synonym for doing) to include a holistic view of the patient; taking time to get to know patients and their needs. When with patients Anne would reflect on the question, “how does this patient want me to show them caring?” For Anne, responding to this question meant being in tune to emotional cues and patient responses to nursing care. Caring resulted in feelings of support, understanding, reassurance, and comfort. Caring was also juxtaposed by uncaring. Although hesitant Anne shared her experience of uncaring that involved a lack of support from an instructor in the clinical setting that resulted in her feeling stupid and embarrassed. This experience stuck with Anne and had a major impact on her meaning of caring and uncaring.

Martha and Anne’s Combined Meaning of Caring

Prior to nursing the meaning of caring for participants was largely informed by caring experiences with family and friends in both health care and non-health care settings. It involved things such as hands on tasks done by nurses to family members who were unwell, unconditional love and tender and compassionate care from family members. Upon entering an undergraduate nursing program their meaning of caring began to change. It became more about respect, privacy, and maintaining dignity, which echoes the outcomes of the program ability, professional identity. Participants recalled that caring was starting to become a part of their professional identity in first year. During their time in the BN program their meaning of caring became more in depth; caring could take on different meanings based on the needs of patients. Participants’ meanings of caring also became more holistic in nature; caring for the patients physical, mental, and spiritual needs. Caring meant being aware of and responding to patients’

cues. In addition to participants' meaning of caring for patients, participants identified their meaning of caring as it related to their need to be cared for as nursing students. For participants of this study, being cared for as nursing students meant feeling understood, respected, and supported in learning.

Martha and Anne's Combined Meaning of Learning Caring

For Martha and Anne, learning caring meant a transformation in their meaning of caring and an embodiment of caring in clinical practice. Martha and Anne explained a reflective process that they engaged in to develop their meaning of caring and to embody caring in their practices as nursing students. To embody caring Martha and Anne had to put into action their values and beliefs about caring. The transformation and embodiment involved a heightened awareness to patients' holistic needs and their ability and responsibility as nursing students to address those needs with caring. Martha and Anne connected caring and nursing without recalling a lot of direct guidance in their education experiences (e.g. in the clinical and classroom settings). Although they felt caring was present in their education experience, participants could not recall it in a direct way. Martha and Anne connected caring and class content on their own. For Martha and Anne to learn caring, caring needed to be embodied in clinical practice through tools such as therapeutic and professional communication, addressing the social determinants of health, and patient centered care. Martha and Anne's lived experiences of learning caring occurred in moments, critical learning turning points, in addition to the entirety of the BN program. Transformation and embodiment of caring over the entirety of the program involved a carrying forward of critical learning turning points that impacted students' meaning of caring. Time, awareness (of self and others), and an emotional response were part of Martha and Anne's lived experiences of learning caring.

Table 8

Phenomenological Themes and Sub-Themes of the Phenomenon Learning Caring

Phenomenological Themes	Sub-Themes	
1. Transformation in the meaning of caring	• Time	• Learning in the moment (critical learning turning points) • Progression over time • Realizing the transformation
	• Awareness	• Self • Others
	• Emotional response	• Caring • Uncaring
2. Embodiment of caring	• Clinical	• Self • Others
	• Tools to embody caring	• Communication • Social Determinants of Health • Patient Centered Care

Table 9

Phenomenological Themes of the Phenomenon Learning Caring and Supporting Quotes from Participant interviews

Phenomenological Theme	Supporting quotes (participant pseudonym)
1. Transformation in meaning of caring	• “...caring in nursing I think it’s a lot more than I thought when I entered the nursing program...” (Martha)
	• “...my meaning of caring has changed...” (Martha)
	• “...[nurse educators] told us that our whole mindset was going to change and it really does.” (Anne)
	• “You think differently and that’s just that whole idea of caring as a nurse, it takes a while to come together.” (Anne)
2. Embodiment of caring	• “...just going in and doing it...” (Anne)
	• “...so you kind of learn as you go. Like each patient is

unique in how they want you to kind of show them caring.” (Anne)

- “...get out there and actually interact with patients...” (Martha)
 - “...when we go into the clinical setting I really see myself and other students thinking about the patient more beyond just the things we need to accomplish...” (Martha)
-

Phenomenological themes. As outlined in Table 8 the meaning of learning caring for participants was made up of two phenomenological themes including a transformation in their meaning of caring and an embodiment of caring in clinical practice. A transformation in their meaning of caring is a complex change that happens over time in the BN program. Embodiment of caring, for participants, meant putting into action their values and beliefs about caring. Table 9 outlines quotes from each participant that support the phenomenological themes.

Each phenomenological theme consists of sub-themes (see Table 8).

Participants’ transformation in their meaning of caring involved time, awareness, and an emotional response to caring and uncaring experiences. Participants’ embodied caring and noticed others’ embodiment of caring in the clinical and classroom settings.

Participants embodied caring using tools provided to them through their nursing education experience.

Transformation in their meaning of caring. The first phenomenological theme of learning caring is a transformation in their meaning of caring. The participants described their transformation as a change in thinking, attitudes, and mindset. Each participant described a transformation in their meaning of caring that is described in more detail above in Martha and Anne’s combined meaning of caring. For example,

although communication was described by participants of this study as an essential component to their meaning of caring, they also described communication courses as *less than exhilarating, not the fun stuff, and bird courses*; however, through a transformation in their meaning of caring, participants described an eventual awareness of the value of communication as part of caring nursing practice. The transformation in their meaning of caring was made up of time, awareness, and an emotional response.

Time. For participants of this study, time involved learning in the moment (critical learning turning points), learning over time in the BN program, and becoming aware of learning caring in the last year of the BN program. Critical learning turning points were made up of critical experiences that contributed to a transformation in their meaning and embodiment of caring. For example, one participant described a clinical experience that took place in the first year of the BN program that continues to impact their meaning and embodiment of caring today. When describing the experience, the participant said, *...that really stuck with me and now I always try to remember that...* Like the one described by the participant, critical learning turning points occurred most often in clinical settings and involved caring and uncaring encounters that resulted in comfortable and uncomfortable emotions. An example of a comfortable emotion was satisfaction and an uncomfortable emotion was embarrassment. The emotional response experienced by participants is discussed in more detail in the Emotional Response section later in this chapter. In addition to learning in the moment, participants' meaning of caring also transformed over time as they progressed through the BN program. As one participant put it, *[caring] is something over the years [in the BN program] that you build upon...* This involved building on their meaning of caring over time by carrying forward what was learned in critical learning turning points. For

example one participant shared *...the first clinical experience went a long way in terms of learning about caring because we didn't have a ton of skills in that first clinical rotation...* Participants also described remembering what was felt and realized in the moment. Participants explained that they became aware of their learning caring late in the BN program, specifically in the last year of the four year program. For example one participant said, *I don't think I even got it [caring] until last year or really even this year...it takes a while to come together.* When describing learning caring, the other participant said about the fourth year of the BN program, *...[caring] was more like theory, just this information, and then it wasn't until this year, I feel like those things started to be all connected...* Both participants described being satisfied with their caring identity, including their meaning and embodiment of caring, as professionals.

Awareness. Awareness involved a heightened awareness of self and others. During the member check interview the participant emphasized experiencing an increased level of awareness through clinical practice, especially as they spent more time with patients and families in the clinical setting. Also, during the member check interview, the participant reinforced the notion of simultaneously becoming more aware of their self and others, for example patients. Awareness of self involved being aware of and engaged in a reflective process to connect learning with caring, to recognize self as caring, to learn from uncaring, and to feel good about caring. Both participants identified as caring individuals before entering nursing and also recognized their professional responsibility to be caring as nursing students and future RNs. One participant described their responsibility to choose to be caring; they said, *...we can really make a difference if we hopefully choose to pick up that piece because [caring] is something that can be forgotten if you don't ... take the extra initiative to care...* When describing

their experience of learning caring in a classroom setting, one participant said ,
...[caring] wasn't identified as caring directly. Instead, the participants' recalled engaging in an independent process of connecting their meaning of caring to what they were learning about in the BN program. As one participant put it, caring is *something that we have to take in and internalize then be like "okay I need to take this and run with it and see how I can build my self into it but still have that nursing lens of caring..."* In the clinical setting one participant described getting *caught up in my head*, by focusing on a to do list of tasks and not necessarily listening to the patients. Once they became aware of the need for caring, participants described engaging in caring with patients and family members. Participants also described being aware of uncaring encounters. One participant, although hesitant, said, *I feel like there's been moments where us as students have felt uncared for in terms of the way things were taught...* In addition, the participant commented on staff nurses in the clinical setting sharing that, *sometimes cover nurses haven't always been the most caring...* In an attempt to temper the powerful emotions they felt during uncaring experiences, participants engaged in a reflective process to learn from the uncaring encounter. Part of this process involved coming up with ways to be caring in similar circumstances. For example, one participant explained that they would always be sure to support people in meeting their learning needs in a helpful and understanding way. Participants also described feeling good about caring. Feeling good about caring involved feeling cared for by nurse educators through support, respect, understanding and taking time to get to know nursing students as individuals. Feeling good about caring also involved receiving verbal affirmations from patients, nurse educators, and self. For example patients and family members said things like *thanks so much and you're going to be a great nurse.*

Participants recalled saying things to themselves like, *I made the right choice [to be a nurse] and [nursing] is where I want to be.*

Awareness also involved being aware of others including patients, nurses, and nurse educators. Through a heightened awareness of others, participants were more open to patients' feelings and needs. Participants described being aware of patients' emotional cues including patients' responses to caring and uncaring. For example a participant shared about caring for a patient and their family saying, *...[I was] actively thinking about how [caring] may be impacting the family...* The participant described drawing on knowledge gained in a nursing class about families - caring for the family was a way to care for the patient. Another participant described being aware of and *...picking up on those non-verbal cues...* when interacting with patients and families. Participants in this study were also aware of nurses' and nurse educators' embodiment of caring and uncaring. That is, they noticed how nurses and nurse educators put into action their own beliefs and values about caring. One participant described a caring nurse educator as *always open to helping and helping like a colleague, but also modeling everything she was teaching...* Another participant described being cared for as *being acknowledged as a person.* The same participant described a caring nurse educator as someone who *[makes] you feel like you can do it rather than making you feel bad...* Participants' awareness of embodiment of caring and uncaring is discussed in more detail in the section, below entitled, Embodiment of caring

Emotional response. As part of their transformation, participants seemed to experience an emotional response during critical learning turning points both caring and uncaring in nature. Student participants' experiences suggested that an emotional response during a learning turning point impacted learning caring by transforming their

meaning and/or embodiment of caring. Participants shared vivid memories of how caring and uncaring encounters made them feel. Emotions ranged from comfortable emotions during caring encounters (feeling great, reassured, affirmed, and supported) to uncomfortable emotions during uncaring encounters (embarrassment, tension, and dissonance). For example one participant said when describing caring for a patient and their family, *it brought [caring] to the forefront, but I kind of felt bad I hadn't been doing it all along*. After reflecting on the caring encounter, the same participant shared that they *[felt] great* about the caring they had engaged in with the family member and patient. This was an influential learning experience for the participant. Another participant described a critical learning turning point in which they engaged in therapeutic communication with the patient and spouse, although initially hesitant, the participant said they *felt accomplished*. The experience seemed to reinforce the value of caring for the participant. One participant explained that being cared for by nurse educators *makes you feel like, "okay next time I see this I'm going to be able to take it on myself rather than being kind of beat down", being like "oh well now I feel like I can't do it..."* Participants were aware of feeling tension around caring and uncaring. For example one participant said about caring, *...so I kind of felt bad that I didn't really recognize all this time that one extra step could go a long way in helping patients and the families be at ease*. When sharing an uncaring experience one participant said, *Well it definitely makes you not feel comfortable to ask questions...so that makes it hard to learn...* Emotions seemed to be an essential component of critical learning turning points. In addition, one participant explained that when they were cared for by their clinical instructor, that is *supported, respected, understood, and acknowledged as a person*, they felt *more comfortable and look[ed] forward to going into clinical*, instead

of *dreading going to clinical* when they felt their clinical instructor was uncaring. In some cases the emotional response to uncaring was so strong that participants seemed to re-live some of the emotion when describing the experience during the interview. This was evident through body language and demeanor.

Embodiment of caring. The second phenomenological theme is the embodiment of caring, or as one participant put it, *just doing it*; the embodiment of caring involved putting into action ones values and beliefs about caring. To learn caring, participants had to embody and watch others embody caring. Although not mentioned by participants in an explicit manner, when having face-to-face interactions with patients participants seemed to use their bodies in learning caring; for example when practicing communication and psychomotor nursing skills. Subthemes for the embodiment of caring include clinical and tools to embody caring. Subthemes are discussed below.

Clinical. According to participants, embodiment of caring occurred in the clinical setting because that was where they became aware of themselves as caring student nurses responsible for caring, while at the same time being aware of others' embodiment of caring and uncaring. One participant explained that the *...experience of just going in and doing it and learning as I went, that was a really good way to learn caring...* Embodiment in the clinical setting involved participants putting into practice their beliefs and values about caring, bridging the gap between their own meaning of caring and caring practice. As one participant said about a critical learning turning point in clinical practice, *it was really important for me to have something like that tangible example to see that it's not just a series of tasks in nursing...* Another participant, when asked about caring in the nursing education experience, said, *...we go through a lot of communication courses and methods and I think that we learn that caring through*

...communication tools... Tools to embody caring are discussed in more detail in the section below entitled, Tools to embody caring. During the face-to-face interactions with patients in the clinical setting, participants practiced their nursing skills and became aware of themselves as caring and responsible for caring while at the same time becoming aware of others' embodiment of caring and uncaring. One participant described asking themselves, in the clinical setting, *how is this person going to respond based on what I'm going to say?* Embodiment involved participants putting into practice their values and beliefs about caring. For example one participant recalled realizing in the clinical setting, in the first year of the BN program, the need for caring, they said, *...oh, so this is how you have to speak and this is how you have to carry yourself and how you have to be with a patient.*

It was also in the clinical setting that participants' described taking risks to embody caring. One participant said, *...sometimes as students you hesitate because you're not sure of yourself ... especially in the clinical setting, ...it can be daunting to go into a room with someone who has all these different things going on and feel like you can talk to them about that or just even be really present with them...* One participant explained that for them, *getting our feet wet [in clinical]...actually interacting with people, although scary, was huge in learning how to actually care for people...* Participants described engaging in therapeutic communication as a risk because of the potential for making a mistake – saying or doing the wrong thing. Participants needed to feel safe to make mistakes, as one participant put it, *some of the best learning [came] from making mistakes.* Taking a risk required encouragement and motivation to initiate dialogue with patients and family members about sensitive topics such as contraception and the need for a blood transfusion. For example one participant described a critical

learning turning point in which they were encouraged and coached by their clinical instructor on how to engage in a sensitive discussion with a patient and their spouse. After embodying caring through communication, the participant described feeling *like they made a difference with [the patient] and felt like the patient would be able to go forward feeling more comfortable*. Participants described feeling hesitant to engage in therapeutic communication for fear of saying or doing the wrong thing, but subsequently feeling satisfied once the communication had occurred because the experience helped transform their meaning of caring and increase their confidence in embodying caring.

Participants were also very aware of others embodiment of caring and uncaring, especially that of nurses and nurse educators. They described talking about and observing caring and uncaring interactions. Their observation and subsequent reflection and discussion about the interactions had a direct impact on their own meaning and embodiment of caring. For example, one participant shared about the value of talking about clinical experiences, in clinical, with peers and clinical instructors, so as to *[pull] things from each other, and reflect* on the experience. Participants described observing caring and uncaring encounters then engaging in a reflective process to either incorporate others' meanings of caring into their own meaning of caring or reflecting on uncaring encounters including what can be learned from the encounter. In addition, participants were keenly aware of nurse educators' embodiment of caring, not only with patients, but also with nursing students in the clinical and classroom settings. If a nurse educator did not acknowledge the student on a personal level such as using their first name or supporting them in their learning by answering questions or explaining a topic in different ways, they were described as uncaring. As one participant put it when recalling an uncaring experience with a clinical instructor, ... *I was so embarrassed and I*

felt so crappy after that and then my day was just so busy..., it wasn't the way that me as a student and how I learn, that wasn't the way that was right for [them] to respond to that situation for me and I just felt really awful in that moment... A caring nurse educator was described as someone who checked in with students on a regular and individual basis to see how they were doing, who was understanding and flexible in their teaching, and referred to students by their first name. Nurses and nurse educators who embodied caring were viewed as role models. As one participant put it when talking about a caring clinical instructor, *[they] were teaching us about privacy and dignity, and professionalism in the way we were acting, [they] would model that, like when [they] would come into the room [they] would be helping as if [they] were a colleague and also modeling all the things [they] were teaching...*

Participants' meaning and embodiment of caring were directly impacted by positive and negative role models in their nursing education experiences. In particular, if participants felt cared for by nurse educators in the clinical and classroom settings they were motivated to be caring with peers and patients alike. For example one participant said, *...that support from your instructors and your peers kind of helps you...have that caring attitude and ...when you have that caring coming at you from your instructor and from your peers it kind of helps you to influence, it kind of influences you to keep trying [to be caring]...* When observing nurses and nurse educators who embodied uncaring, participants reflected on this experience and became aware of how they did not want to be as nursing students and future registered nurses. For example one participant said about an uncaring experience with a clinical instructor, *...that was a very condescending moment for me and I wouldn't want anybody to feel like that...that's kind of how [that experience] influenced me...* Participants described the observation of

caring role models as having an impact on their meaning and embodiment of caring.

Nurse educators were viewed as role models if they competently used tools to embody caring in the clinical and classroom settings.

Tools to embody caring. Participants' embodiment of caring in the clinical and classroom settings was influenced by the tools and resources offered to the participant. On participant said, *...I think we learn caring through those kind of communication tools, like how we need to approach someone...* During the member check interview the participant reinforced that tools were and continue to be very helpful for the embodiment of caring and emphasized that tools are even more helpful when students are not only exposed to the them, but also taught how to best use the tools. This was done through role modeling. Tools were described as whole courses or concepts within courses, that provided participants with tangible means to embody their meaning of caring. For example, students highlighted courses that focused on developing professional and therapeutic communication, the social determinants of health, and patient centered care (identified by Martha). When asked about how caring is integrated in their nursing education experience, one participant said, *...we talk a lot about patient centered care and different ways that we can communicate and inform people and allow them to be a part of the process through advocacy...* Tools provided participants with tangible techniques to apply caring in concrete ways in their nursing practice. For example participants shared about engaging in communication techniques with patients and family members such as listening and providing education or information sharing. In terms of the social determinants of health, participants shared how a discussion about patient needs within the context of the social determinants of health, such as socioeconomic status, was important for example in determining whether a patient had

access to a prescribed medication. The social determinants of health provided a means to determine a unique patient need, which, for participants of this study, was a way to evoke caring. One participant said, *We talk a lot about the social determinants of health...* Another participant, when sharing about caring and the social determinants of health said, *...we get more training of looking at all the aspects of the patient instead of just hands on experience and hands on tasks...I feel [caring] is more looking at the big picture.* For Martha, patient centered care, meant advocating and prioritizing patient needs by listening to patient needs then acting to address them. With the necessary tools, participants felt equipped to embody caring in the clinical setting. In describing their meaning of caring and learning caring, participants also identified factors that facilitated and/or limited their learning caring. These factors are outlined below.

Factors that Facilitated Learning Caring

Participants were asked, what in their nursing education experience facilitated learning caring? Many factors were identified including internal factors, those that stemmed from the participant themselves and external factors, those that stemmed from anyone or anything other than the participant. Internal factors that facilitated learning caring in this present study included valuing caring and identifying as being a caring individual prior to entering the nursing program, motivation or initiative to *pick up* caring in nursing education, self-talk, and feeling the difference caring made for patients and nursing students alike. External factors that facilitated learning caring included course design and instructional methods; nature and availability of tools to embody caring; feedback from patients, nurse educators, and nurses; being cared for by nurse educators; support in the clinical setting to embody caring; caring role models; and caring and uncaring encounters.

Valuing caring and identifying or being identified as a caring individual prior to entering the nursing program was a facilitating factor for learning caring. Friends and family played a significant role in the experience of learning caring prior to nursing education. Participants' experiences with caring prior to nursing provided a foundation on which to build their professional knowledge of caring. A willingness and motivation to learn caring also stemmed from valuing and identifying as caring prior to their nursing education. In addition, being motivated in general to learn and grow as a nurse was also an internal factor that facilitated learning caring.

For participants in this present study, self-talk manifested as reassuring oneself through inner dialogue. Self-talk seemed to occur before, during, and/or after a critical learning turning point in which the participant was caring with a patient, they observed caring or uncaring, or they were cared for. Participants shared about positive self-talk that occurred during a caring encounter. During an uncaring experience, participants described a flood of thoughts related to the consequences of uncaring. Before a critical learning turning point, in addition to being encouraged by their instructor, participants described drawing on their course material, for example communication techniques, to facilitate the caring experience. This required reflection to help participants feel more prepared for the interaction. After a caring experience, through self-talk, participants reflected on the effectiveness of caring and reinforced their choice to be a nurse. After an uncaring experience, also through self-talk, participants reflected on how they did not want to be as nursing students and nurses.

Feeling the difference caring made for patients and nursing students was also an internal facilitating factor for learning caring. When participants had an emotional response to caring or uncaring, they tended to reflect on and, at times, experience an

epiphany that developed their meaning and embodiment of caring. In addition, when participants understood the unique needs of patients and families including how caring could be used to address those needs, they felt more confident in their choice to be caring.

An external facilitating factor for learning caring, for participants in this study, included specific instructional methods such as reflection, discussion, and role modeling. Instructional methods can be delivered through different settings in nursing education. For participants in this study the classroom and clinical settings were most influential in learning caring, with the clinical setting having a more profound impact. In particular, when instructors who were role models of caring implemented certain instructional methods, such as discussion and reflection, learning caring was facilitated.

Another external facilitating factor is the nature and availability of tools in the classroom and clinical setting, to embody caring. Tools to embody caring in the clinical setting for these participants included communication, social justice, and patient centered care. An example of a communication tool was listening to patients needs and offering education, for example about contraception. An example of a social justice tool included consideration of the social determinants of health when thinking about a patient's ability to afford a necessary medication. An example of a patient centered care tool was advocating for patients. Embodiment of caring through these tools was enhanced when nurse educators were caring with participants. Being cared for meant being understood, supported, and respected as a nursing student. When faculty members role modeled caring with patients and students, students felt more motivated and empowered to embody caring with patients.

Receiving feedback from patients and nurse educators was also described as an external factor that facilitated learning caring. For participants of this current study, feedback from patients often occurred through verbal means and non-verbal means. Using verbal communication, patients made comments; for example telling the participant they will be a good nurse or thanking the participant for listening to them. Non-verbal feedback from patients occurred as participants paid attention to emotional cues such as a patient and spouse demonstrating a decrease in anxiety characterized by changes in body language and tone of voice. Feedback from nurse educators was discussed in more detail above in the section related to tools to embody caring.

An uncaring encounter was identified as an external facilitating factor for learning caring. The facilitating nature of uncaring encounters seemed to depend on the participants' response to the encounter. As a facilitating factor, if uncaring was reflected on in a positive manner, participants described realizing how they did not want to be as nursing students and future registered nurses, then developing their own meaning of caring and embodiment of caring in future encounters. Uncaring encounters shed light on participants' own meanings of caring including a professional imperative to be caring.

Factors that Limited Learning Caring

Participants were also asked about and identified factors that limited their learning caring. Limiting factors stemmed mostly from external influences and included a lack of direct discussions about caring, fact focused or non-nursing courses, an increase in the number and complexity of psychomotor skills, uncaring encounters, and burnout. The only internal limiting factor for learning caring identified by a participant was a potential lack of self-care.

A lack of direct discussion about caring in their education experience was identified as a limiting factor for learning caring. Participants could not recall a time in their nursing education in which caring was learned in a direct manner in a particular course or learning experience. Participants felt they were left to make the connection between caring and the content they were learning in courses.

Another limiting factor included courses that were fact focused or not focused directly on nursing topics. Participants felt that courses such as anatomy and psychology should have a direct connection to nursing including caring. Courses that were combined with non-nursing students could also be limiting when there was not a direct connection to nursing. In addition, if fact focused courses were taught out of sequence from a clinical course (i.e. asynchronous delivery of theory and practice) learning caring was also limited. For example, if students learned about pharmacology, but did not actually administer the medications to patients, then the knowledge was difficult to grasp and/or retain because the contextual element of patients' stories was omitted from the learning experience.

Another limiting factor was an increase in the number of complex psychomotor skills. Given the complexity in executing advanced psychomotor skills, participants explained that as they focused more on the skills, they were more challenged to engage in caring. Their attention was focused on doing and not always being with the patient and/or family. This is interesting because being competent at psychomotor skills was viewed as a part of caring; however, complex psychomotor skills acted as a limiting factor for learning caring. It is important to consider how this potential for dissonance might affect learning caring and how it can be addressed.

Nurses and nurse educators who were perceived as uncaring influenced students' capacity to learn caring. Observing or being the recipient of uncaring encounters that were characterized by a lack of understanding or respect, left participants feeling tension, fear, and intimidation. Participants explained that when they experienced such uncaring encounters, they avoided asking questions or engaging in discussion with the nurse and/or nurse educator who was uncaring. Given that much of learning caring depends on the individual faculty members teaching and implementing caring, an uncaring nurse educator may limit learning caring for nursing students.

One participant highlighted the impact of burnout on nurses' and nurse educators' ability to care and how that had a direct impact on their own learning caring. One participant also identified a lack of self-care as a limiting factor for learning caring. A lack of self care is an internal limiting factor. The participant explained that to care for others one must also engage in self care. One participant stated that being a nurse was *taxing*. The participant suggested that to cope with the taxing nature of nursing, nursing students and nurses should engage in self care. Self-care meant tending to ones own wellbeing and was viewed as a mitigating factor for burnout in nursing, which participants identified as an external limiting factor for learning caring.

Even though they could not recall direct conversations about caring, overall, participants felt that caring was well integrated into their nursing education experience. They explained that they made the connection to caring on their own when learning about professional and therapeutic communication, the social determinants of health, and for one participant, patient centered care. Participants also explained that course design, for example, courses that focused on the holistic needs of patients and families and those that involved lots of discussion and reflection were most helpful for learning

caring because they provided them with opportunities to think about and discuss for example social injustice and the nurses role in addressing it. In addition to class content viewed as caring by participants, participants experienced both caring and uncaring in the clinical and classroom settings directed at students and patients from nurses and nurse educators. Their experience of uncaring however did not out weigh their overall experience of caring in their education experience.

When analyzing the interview data within the context of the curriculum data, many interesting findings were noted. For example, despite asking participants questions such as, *How was caring integrated into your nursing education experience?*, participants could not recall direct learning about caring; that is they could not recall specific class or clinical content related to caring that was addressed in a direct way in their experience. Although caring is integral in the curriculum and is present as a principle, value, philosophical underpinning, and relationship, use of the term caring and related substantive description of caring in the course blueprints that directly impact course design and instructional methods is limited (see Table 7). Limited use of language directly related to caring in course blueprints may contribute to limited focus on and instruction related to caring in classroom, lab, and clinical settings.

To make the connection between classroom and clinical content, participants engaged in an internal reflective process in which they connected caring with professional/therapeutic communication, the social determinants of health, and patient centered care (Martha). Participants meaning of caring is consistent with how caring is present in the course blueprints. As mentioned previously, the word caring is present most often in the learning outcomes of communication and social justice (see Table 5

and Table 7), which directly connects to participants' perspectives related to how caring is lived in their nursing education experience.

Participants also identified caring as a professional responsibility. Caring for participants in this study is an overarching philosophy and a professional imperative that is holistic, personalized, communication and action oriented, and impacts all nursing including nursing education. Participants recognized that all patients deserve caring. It is interesting to note that the word caring does not appear in any of the outcomes of professional identity (See Table 5 and Table 7) even though professional documents such as the NANB Standards of Practice for RNs (NANB, 2008) and the Canadian Nurses Association Code of Ethics (CNA, 2007) are identified in *The Big Picture* document as sources to support caring in the curriculum. Even though language related to caring is missing from the program ability professional identity, participants made the connection between their role as professionals and a need to be caring as nursing students and future RNs. It is important to think about the possibility that some nursing students may not make the connection between their professional role and responsibility to be caring for all patients. This points to a need for a clear definition of caring in the curriculum.

Another interesting finding is related to participants' realization of their learning caring. As mentioned previously, participants identified that they became aware of their learning caring (i.e. their transformation and embodiment of caring) in the last year of the four year BN program. This is interesting because, as per the curriculum documents, caring language appears least when referring to the fourth year of the BN program (See Table 6). Not all nursing students may be equipped or prepared to make the connection between caring and their own practice as nursing students and nurses. This realization,

for some, may need to be guided by nurse educators. If caring is missing from the fourth year curriculum, nurse educators may not be prompted to include caring in course design and instructional methods, which may mean that some nursing students do not experience what participants called a *wake up call* or a realization of their learning caring. This may too perpetuate a loss of caring as nursing students become RNs.

Another important finding relates to the embodiment of caring in the educational setting. Participants' lived experience of learning caring involved embodiment of caring, their own embodiment and the embodiment of nurse educators. As noted in the curriculum document analysis, caring appears in a theoretical or abstract manner in the *FON Vision, Mission, and Values* document and *The Big Picture* document. However, as mentioned previously, a means to embody caring for both faculty members and nursing students alike is missing from the curriculum documents. Although caring as a value is meant to guide all faculty interactions, how to incorporate caring into interactions is not made clear for faculty members. If faculty members and nurse educators do not embody caring, nursing students may not have the necessary role models needed for learning caring,

Through the research process of reading, writing and rewriting, language was used to describe and understand nursing students' lived experiences of learning caring in a curriculum that has caring as a core value. To achieve a phenomenological text through writing and rewriting, all data and its parts were considered over and over (van Manen, 1997). Reflection, patience, and a commitment of time were required to make clear, through text, the meaning of nursing students learning to care in a curriculum that has caring as a core value.

In the next chapter, Chapter five (Discussion), findings from this chapter will be discussed within the context of existing research related to caring and learning caring for nursing students. Comparisons will be made between the findings of this study and existing theoretical and research literature. In addition, a discussion about what this research study adds to the existing body of research literature related to nursing students' experiences of learning caring will be presented. Limitations of this study will also be discussed.

Chapter 5: Discussion

The purpose of this study was to explore the research question, “What is it like for BN students in a four year program to learn caring within a curriculum that has caring as a core value? The aims of the study were to describe and understand:

- the meaning of caring for nursing students;
- the meaning of learning caring for nursing students;
- factors within nursing education that facilitate and/or limit learning caring for nursing students; and
- how caring is lived from the nursing students’ perspectives within a curriculum that has caring as a core value.

This study is based on a major assumption that caring can be learned. Although the evidence is overwhelming to support that caring can be learned (Allis, 1992; Drumm, 2006; Drumm and Chase, 2010; Eskilsson, Horberg, Ekebergh, & Carlsson, 2014; Lake, 2004; Ma et al. 2014; Paterson et al. 1995, 1996; Solvoll & Heggen, 2010; Sitzman & Watson, 2017), I have witnessed nursing students and nurses argue that caring cannot be learned; that is, if you are not caring already, you cannot learn to be caring. I too held that view at one point in my career as a nursing student and nurse, but have since changed my perspective. Research could not be found to suggest that caring cannot be learned or whether or not there is a genetic component to caring. In order to understand more about the meaning of caring and learning caring in nursing education, the following discussion is offered.

The Meaning of Caring

As outlined in Chapter one (Background) a definition of caring was not offered for this study a priori. Instead it was suggested that a definition of caring would be gleaned from this study thus the meaning of caring as it arose from this study is presented here. For participants of this study caring is an overarching philosophy and a professional imperative that is holistic, personalized, communication and action oriented, and impacts all nursing including nursing education. It is important to note that as analysis of curriculum documents occurred it became clear that a specific definition of caring, based on any one theory, was not evident. A description of caring, as it exists in the curriculum documents and the lived experiences' of participants, is provided. These descriptions were compared to one another.

In the curriculum documents caring is identified as a principle, a value, a philosophical underpinning, and a type of relationship. Leininger's (1991) Theory of Transcultural Care is the only theory referenced in the curriculum documents when describing caring, for that reason it is important to reflect on Leininger's definition of caring. As mentioned in Chapter one (Background and Significance), Leininger (1991) identifies caring as a gerund and defines it as *actions and activities directed toward assisting, supporting, or enabling another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway, or face death* (p. 46). Leininger's definition of caring emphasizes that, caring is grounded in *actions and activities* (Leininger, 1991, p. 46). Leininger (1991) identifies caring as the essence of nursing. It is important to note that even though Leininger's (1991) theory is used as a reference in the curriculum documents, Leininger's definition of caring is not used in a direct way in the curriculum documents and participants did not make reference to

Leininger's theory; however, much like Leininger's definition of caring, participants descriptions of caring are very action oriented.

Prior to nursing, the meaning of caring for research participants in this study was largely informed by their personal experiences with family and friends. Caring was described as a value, as part of their identity, and involved things such as hands on tasks, unconditional love, and tender and compassionate care from family members. As their meaning of caring evolved it also became about respect and maintaining dignity and privacy; caring became a professional imperative embodied through therapeutic and professional communication, social justice, and patient centered care. The emphasis on communication and social justice is indicative of how caring is represented in the curriculum documents. As mentioned previously in the section, curriculum document analysis, when present, caring is frequently in the learning outcomes of social justice and communication. Although participants did not recall any particular caring theory, Sumner and Fisher (2008) agree with the idea of caring as communicative action. In their study, caring in nursing was defined as *...communicative action framed by the unconditional universal thought of respect for all human life, encompassing the spectrum of human experience and is manifest in the verbal and nonverbal discourse between 2 equal and vulnerable human beings* (Sumner & Fisher, 2008, p. E22). As participants spent time in the BN program, their meaning of caring deepened; caring took on different meanings based on the holistic needs of patients and continued to be embodied through therapeutic and professional communication, social justice, and patient centered care. Participants also identified their meaning of caring in terms of being cared for which involved feeling respected and supported in their learning.

Similarities and differences were noted when analyzing the description of caring in the curriculum documents compared to the description offered by participants of this study. Similarities included language used to describe caring, a focus on communication and social justice as caring, and a missing connection between nursing and caring.

The use of words such as compassion, dignity, and privacy to describe caring is in line with professional language, such as that used in the code of ethics (2008) and practice standards (2013). It is important to note that although caring does not appear in the curriculum documents as part of the program ability, professional identity, participants focused on the professional imperative to be caring. This may be representative of the participants' lived experiences of learning caring in first year of the BN program in a course entitled, Professional Relationships (N1032), which has a focus on developing professional relationships through professional communication (see Table 7). As mentioned previously, N1032 is the only nursing course in the BN program that has caring as part of the course description. In the first year of the BN program, participants recalled learning caring when learning about professional responsibilities and communication. In the first year of the BN program participants were beginning to develop their own professional language. While the language of caring was not explicit, participants seemed to make links between caring and what they were learning in the BN program. Making the link more explicit through the language of the curriculum documents, including the abilities and outcome statements, could enhance their capacity to identify and learn caring.

For participants of this study, caring is described predominantly in terms of communication and social justice. A focus on communication and social justice as caring is reflective of caring as it exists in the course blueprints. A brief description of

course blueprints is provided in Table 1 in the Methodology and Methods chapter (Chapter 3) and an in depth description of the course blueprints is provided in Chapter four (Findings). Although participants were clear in their use of professional and therapeutic communication and social justice language to connect their learning experience with caring, the connection was not as evident in the course blueprints. It was only after careful analysis of the language used across the entirety of the curriculum documents, that caring language was noted as part of the program abilities, communication and social justice. Even though the language of caring is integrated into course outcomes related to communication and social justice, participants described making the connection between caring and communication and social justice on their own.

Within the curriculum documents, an assumption about caring is that caring is a moral imperative (Leininger, 1991). Leininger's theory is cited as a reference for caring as a moral imperative; however the meaning of a moral imperative in this context is not explained beyond being a biophysical, psychosocial, spiritual, cognitive, (Leininger, 1991) and sociopolitical (Bent, 1999) phenomenon. Participants of this study described caring more as a professional imperative through descriptions of maintaining respect, dignity, and privacy. In the curriculum documents, caring is presented in abstract terms through references to values and assumptions whereas participants highlight the embodiment of caring which involved putting into practice their meaning of caring. Caring for participants in this study is an overarching philosophy and a professional imperative that is holistic, personalized, communication and action oriented, and impacts all nursing including nursing education. Participants identified with caring as a professional imperative, emphasizing that everyone deserves caring and it is their

responsibility as nursing students and future registered nurses to be caring with all patients. As noted in the Findings (Chapter 4), caring was not present in an explicit way in any program outcomes related to professional identity; however, participants described their meaning of caring using language consistent with the program ability.

Participants focused on the embodiment of caring. The embodiment of caring was not evident in the curriculum documents; instead in the curriculum documents, there is a focus on caring and caring relationships in a more abstract manner. As pointed out in Chapter four (Findings), it may be helpful to incorporate an action oriented approach to caring in *The Big Picture* document and course blueprints. A strategy might be to include, in *The Big Picture* document, narratives of nurses implementing the curriculum values, including caring, in everyday actions and activities. Given the action oriented approach of Leninger's (1991) theory, pointed out above, one could conclude that if Leininger's definition and theory of caring were used to guide the curriculum, the embodiment of caring might be facilitated.

The Meaning of Learning Caring

The research question was explored using van Manen's (1997) phenomenological research method. In this study I (the researcher) identified two main phenomenological themes and five subthemes common to participants' lived experiences of learning caring in a bachelor of nursing program with caring as a philosophical underpinning/foundation, value, and relationship in the curriculum. The two phenomenological themes for participants included a transformation in their meaning of caring and an embodiment of caring. The phenomenological theme, transformation in their meaning of caring, is made up of three subthemes including time, awareness, and an emotional response. The phenomenological theme, embodiment of

caring, was made up of two subthemes including clinical practice and tools to embody caring. The phenomenological themes are discussed in more detail below.

Transformation in their meaning of caring. Participants in this study described a transformation in their meaning of caring that involved a flip in thinking and attitudes and a change in mindset which is consistent with findings from existing research. Nursing students in other studies experienced learning caring as a transformation that was characterized by an epiphany (Lake, 2004), heightened awareness or consciousness (Kosowski, 1993, 1995), or new insights and coherence (Eskilsson et al., 2014). Patricia Benner (1984), a nurse theorist and researcher, also supported the notion of transformative learning in her theory of skill acquisition entitled *From Novice to Expert*. Benner (1984) suggested that nursing students evolve along a continuum of expertise from novice to expert, which is informed by theoretical and experiential or practical knowledge.

As highlighted by the external reviewer for this thesis, a transformation in their meaning of caring also connects with Patricia Cranton's (2011) description of transformative learning theory. For Martha and Anne transformation often took place in the clinical setting after witnessing a caring or uncaring experience that challenged their existing values and beliefs and resulted, in some cases, with dissonance or tension. How Martha or Anne responded to the dissonance or tension seemed to determine the learning that occurred. Cranton (2011) explained that when currently held values and beliefs are brought into question by some sort of dilemma and critical reflection occurs, there is a potential for transformative learning. Cranton (2011) suggested that transformative learning has occurred when there is a deep shift in perspective that results in noticeable action.

Time. van Manen (1997) described lived time or temporality as a component of the lived experience highlighting that, *Lived time is subjective time as opposed to clock time or objective time* (van Manen, 1997, p. 104). To better understand the meaning of lived time, van Manen (1997) suggested considering the question, what makes time go by slow or fast? For participants of this study, lived time (van Manen, 1997) involved learning in the moment (critical learning turning points), learning over time in the BN program, and becoming aware of learning caring in the last year of the BN program. Although time is not discussed in an explicit manner in the existing learning caring literature, one study, a narrative case study conducted with nursing students, described learning caring on a continuum (Hoffman, 2013). Stages on the continuum were learning about oneself, learning about others, and learning to be a care provider. Progression along the continuum coincided with students' progression through the baccalaureate program. This echoes the findings of this study in which participants described cumulative learning that resulted in a culmination and awareness of learning caring in the last year of the four year BN program. Benner (1984) suggested that knowledge develops "over time in the practice of an applied discipline" (p. 1).

Awareness. For participants in this study, awareness involved a heightened awareness of self and others. Self awareness involved being aware of and engaged in reflective processes to connect the learning experience with caring, to recognize self as caring (internal motivation and a professional responsibility), to reverse (Kosowski, 1993, 1995) uncaring, and to feel good about caring. Patterson et al. (1995) described a reflective process nursing students engaged in that was made up of confusion and uncertainty about their ideas of caring, reflecting on the right answer, and then discovery about how to integrate new assumptions and let go of previously held ones. Allis (1992)

and Kosowski (1993, 1995) suggested that students' experiential knowledge both personal and professional contributed to their learning caring. Participants in this study discussed their personal and professional experiences that led to a transformation in their meaning and embodiment of caring. Drumm (2006) and Drumm and Chase (2010) described learning caring as coming to know self as caring. Knowing self as caring involved enhancing one's caring ability. For some students, self was described in terms of feeling good when caring (Kosowski, 1993, 1995), for other students self was represented by a need to be cared for (Paterson et al., 1995), and for yet other students, self emerged from the data as a need for self preservation and a need to feel motivated by their nursing supervisor (Eskilsson et al., 2014).

Awareness also involved being aware of others including patients, nurses, and nurse educators. Through a heightened awareness of others, participants were more open to patients' feelings and needs. Participants described being aware of patients' emotional cues including their responses to caring and uncaring. In one study, this resulted in the students being more sensitive to, and in tune with their environment and patients' unique context (Kosowski, 1993, 1995). Students needed to recognize their own ability to care for patients' unique needs in the clinical setting (Eskilsson et al., 2014). Coming to know self as caring involved being present with patients and being open to reshaping the experiences of patients (Drumm, 2006; Drumm & Chase, 2010).

In addition, in terms of being aware of others, participants in this study were aware of nurse and nurse educators' embodiment of caring and uncaring. In particular, they were keenly aware of whether they were being cared for in the clinical and classroom settings and whether patients and family members were being cared for by nurses, nurse educators, and themselves alike. Participants' awareness of embodiment

of caring and uncaring is discussed in more detail below in the section, Embodiment of caring

Emotional response. As part of their transformation, participants also experienced an emotional response, especially during critical learning turning points. During critical learning turning points, participants experienced comfortable and uncomfortable emotions. Feeling comfortable, for participants in this study, meant feeling safe in their environment. For participants in this study when their caring ideals were challenged through the observation of uncaring in the clinical setting, they had an emotional response. Mathew, Ng, Patton, Waschuk, & Wong's (2014) study supports this finding, stating that much of what participants learned arose from uncomfortable feelings and emotions such as tension. Feeling uncomfortable, for participants of this study, occurred during uncaring encounters in the classroom and clinical settings. In the existing literature, transformation often took place during or after an uncomfortable or distressing experience (Kosowski, 1993, 1995) or an uncaring moment in clinical practice (Paterson et al., 1995).

Embodiment of caring. The second phenomenological theme is embodiment of caring, or as one participant put it, "just doing it [caring]." To learn caring, participants in this study had to embody and watch others embody caring. van Manen (1997) supports the importance of the body in the lived experience when he described the lived body or corporality of phenomena. The lived body refers to being "bodily in the world" (van Manen, 1997, p. 103). According to participants, embodiment of caring occurred most often in the clinical setting. This highlights the importance of clinical and the opportunity to test out ways of caring and also perhaps the link with critical learning moments whereby students reflect on their feelings (comfortable/uncomfortable) based

on their own and the actions of others and make adjustments – thus an iterative and cumulative approach to learning caring. Benner's (1984) theory reminds us that skill development is iterative and cumulative, evolving over time with experience. Much like this, the embodiment of caring evolves over time.

During the face-to-face interactions participants practiced communication and psychomotor skills. The physical body played an important role in the execution of those skills. Other researchers have reported that through verbal and non-verbal communication, nurses and nursing students can send caring and/or uncaring messages to patients (Sumner & Fisher, 2008) and through psychomotor skills nurses and nursing students are using their bodies such as their hands to execute psychomotor skills and communicate caring in the lab and clinical settings (Minnesota Baccalaureate Psychomotor Skills Faculty Group, 2008). In a study conducted by graduate students, and for a time their professor, it was proposed that intellectual learning is often prioritized in academia (Mathew, Ng, Patton, Waschuk, & Wong, 2014). The authors remind us that learning involves the mind, body, and emotion. The study concluded that the learning process is holistic and requires an integrative approach. An integrative approach would include the mind, body, and emotion in the learning process (Mathew et al., 2014).

Clinical. Caring within the clinical or practice setting can have a major impact on promoting caring nursing (Lindberg et al., 2012). Participants in this study recognized themselves as caring including their professional responsibility to be caring in the clinical setting. The importance of the clinical setting is echoed in the existing research literature on learning caring. For nursing students, transformative learning occurred most often in the clinical or practice settings where students' caring ideals were

challenged (Drumm, 2006; Drumm, & Chase, 2010; Kosowski, 1993, 1995; Ma et al., 2014). For participants, the clinical setting is what van Manen (1997) might refer to as lived other or relationality. Relationality in this context might refer to the relationships a person has with people with whom they work and interact. In the clinical setting nurses and nursing students are always in relation with patients, nurses, and nurse educators; therefore learning caring has a lot to do with the relationships that are formed and fostered. Part of developing relationships with people in the clinical setting is achieved through observation of nurse and nurse educators' embodiment of caring and uncaring. For participants in this study their caring ideals were challenged through the observation of uncaring in the clinical setting. Other students made sense of themselves as caring where caring was practiced (Drumm, 2006; Drumm, & Chase, 2010; Eskilsson et al., 2014; Ma et al., 2014; Solvoll & Heggen, 2010) while participants in other studies experienced growth in their confidence and caring abilities as they came to know themselves through practicing caring in the clinical setting (Drumm, 2006; Drumm, & Chase, 2010; Ma et al., 2014).

It was also in the clinical setting that participants described taking risks to embody caring. The risk seemed to be associated with a fear of saying or doing the wrong thing. Similarly, another researcher has reported that to build confidence and resilience, students needed to feel safe and be encouraged to experiment with their learning, make mistakes and view learning as largely formational and not always directed toward a grade (Cornwall, 2018). No studies were found that refer to risk taking and learning caring specifically; however, one study focused on faculty members' learning about information technology (IT). It revealed that faculty members needed to take risks in applying their IT knowledge in the classroom setting (Rock, 2014). To

apply their knowledge faculty members needed to feel safe to make mistakes, to be vulnerable in their learning, and to continue to experiment. For participants in this study, taking risks meant engaging in therapeutic communication about sensitive topics, such as contraception and the need for a blood transfusion. When taking a risk, participants identified feeling hesitant, but subsequently satisfied. Rock (2014) also reported that risk taking supported the transfer of learning.

Participants in this study were also very aware of others' embodiment of caring and uncaring, especially that of nurses and nurse educators. They described observing caring or uncaring nurse interactions with patients and how that observation had an impact on their own meaning of caring. Participants in another study described engaging in a cognitive process to either incorporate others' meaning of caring into their own meaning of caring or reflecting on uncaring encounters and reversing (Kosowski, 1993, 1995) those encounters to also build their own meaning and embodiment of caring. Nurses and nurse educators who embodied caring were seen as role models and played an important role in participants' own embodiment of caring. In line with this, role modeling was the instructional method for learning caring that appeared most frequently in the literature related to learning caring (Allis, 1992; Drumm, 2006; Drumm & Chase, 2010; Kosowski 1993, 1995; Ma et al., 2014). Across a range of sources, learning caring occurred through observing and imitating role models including caring instructors (Kosowski, 1993, 1995), professors (Paterson et al., 1995), nurses (Allis, 1992; Kosowski 1993, 1995; Paterson et al., 1995), and peers (Paterson et al., 1995). Participants of this present study were keenly aware of nurse educators' embodiment of caring, not only with patients, but also with nursing students in the clinical and classroom settings.

Participants' meaning and embodiment of caring were directly impacted by positive and negative role models. In particular, if participants felt cared for by nurse educators in the clinical and classroom settings they were motivated to be caring with peers and patients alike. When observing negative role models, or nurses and nurse educators who embodied uncaring, participants internalized this experience and realized how they did not want to be as nursing students and future registered nurses. This had a direct impact on their meaning and embodiment of caring. Clinical instructors were identified as having a major impact as role models because their caring with patients and students could influence the whole learning experience (Eskilsson et al., 2014; Kosowski, 1993, 1995).

Tools to embody caring. Embodiment of caring in clinical practice required tools to embody caring. These tools were provided to participants in both the clinical and classroom settings of their education experience. Participants in this present study identified tools to embody caring as professional and therapeutic communication, the Social Determinants of Health, and Patient Centered Care (identified by Martha). Professional communication meant communicating using respect, for example by calling a patient by their preferred name. Therapeutic communication involved communication techniques such as active listening and information sharing (Egan & Schroeder, 2009). The Social Determinants of Health (World Health Organization, 2008) provided a way for students to consider patients' holistic needs including their social context, such as socioeconomic status and social support, when planning and implementing nursing care. Patient centered care (Morgan & Yoder, 2012), which Martha identified as advocacy and prioritizing the needs of patients, was also a tool to embody caring.

The tools provided participants in this study with tangible means to embody their meaning of caring. With these tools participants felt equipped to embody caring in the clinical setting. In another study involving nursing student participants, it was identified that the educational setting enhanced their capacity to care by providing them with tools to implement caring (Drumm, 2006; Drumm, & Chase, 2010). Specific tools were not identified in the study. In other studies, however, opportunities for engagement in dialogue, reflection, feedback, and critical thinking about caring in the practice setting were significant tools to learn caring (Eskilsson et al., 2014; Ma et al., 2014, Paterson et al., 1995; Solvoll & Heggen, 2010). Solvoll and Heggen (2010) suggested that if opportunities for dialogue were not provided in clinical and instead there was a focus on tasks and problem solving, students might be left to learn caring in private.

Factors that Facilitated Learning Caring

Many factors were identified in this study and in the existing literature that facilitate learning caring. Facilitating factors were organized based on internal factors, those that stemmed from the participant themselves and external factors, those that stemmed from anyone or anything other than the participant. Factors within the existing learning caring literature that facilitated learning caring were not organized in terms of internal and external factors (see Background and Literature Review).

Learning caring is possible and necessary and is influenced by both internal and external factors. Learning caring must be nurtured in the nursing education experience. Learning caring in nursing education can be facilitated if nurse educators have an understanding of the internal and external factors that influence learning caring.

Internal factors that facilitated learning caring in this present study included, valuing caring and identifying as caring prior to entering the nursing program,

motivation or initiative to *pick up* caring in nursing education, self-talk, and feeling the difference caring made for patients and nursing students alike.

A caring identity and valuing caring prior to nursing may facilitate the process of imagining, a cognitive process described by Kosowski (1993, 1995), that involved students using their imagination to draw on their own life experiences to learn caring. Through the creative process of imagining, students were able to gain insights into patients' need for caring.

Another internal facilitating factor is a willingness and motivation to learn caring. Part of this comes from valuing and identifying as caring, while another part stems from a motivation to learn and grow in general and as a nurse. Sandvick, Eriksson, and Hilli (2014), in a phenomenological study conducted with nursing students in the clinical setting, supported the idea of a will and motivation to become a nurse. Will and motivation *...are based on the students' inner incentives for learning and development* (Sandvick, Eriksson, & Hilli, 2014, p. 289).

Self-talk was identified by participants as a facilitating factor for learning caring. Research literature was not found, in which the role of self-talk in learning caring was explored. Literature related to self-talk is largely conducted with athletes to explore the positive self-talk or inner dialogue they engage in to be successful in their athletic performances (Blanchfield, Hardy, de Morree, Staiano, & Marcora, 2014). In terms of self-talk and learning, one study was found that explored motivational self-talk and its relationship with academic engagement in grade 10 Chinese high school students (Wang, Shim, & Wolters, 2017). Motivational self-talk was described as

self-talk strategies [that] have a clear focus on the regulation of motivational beliefs (e.g. achievement goals, self-efficacy) and involve students' efforts to

remind themselves of their reasons for completing a task or to reassure themselves of their ability to complete a task successfully in order to achieve effort enhancement and persistence in demotivating situations. (Wang et al., 2017, p. 296)

Self-talk was shown to positively influence academic engagement (Wang et al., 2017).

Another internal facilitating factor for learning caring was feeling the difference caring made for patients and nursing students alike. When participants had an emotional response to caring or uncaring, they tended to reflect on and develop their meaning and embodiment of caring. This is discussed more in the section titled Emotional response, above.

External factors that facilitated learning caring included course design and instructional methods, provision of tools to embody caring, support in the clinical setting to embody caring, being cared for by nurse educators, caring role models, feedback from patients and nurse educators, and uncaring encounters. It is important to note that uncaring encounters were also felt to be a limiting factor. If participants did not engage in reversing (Kosowski, 1993, 1995) then uncaring encounters led to unresolved feelings of tension, fear, and intimidation. While participants did not speak directly about the curriculum as an external factor that facilitated learning caring, the use of language associated with descriptions of the meaning of caring is consistent with language outlined in three of the BN program abilities including communication, professional identity, and social justice.

MacNeil and Evans (2005) suggested that caring is promoted through nursing education when a caring pedagogy exists (MacNeil & Evans, 2005). Participants in this study identified that caring needs to be threaded throughout their lived experience in the

BN program. Participants viewed caring as an overarching idea that influences all of their education experience. This is supported by seminal curriculum documents in which caring is an integral part of the BN curriculum.

Even though caring may be represented through language in curricula, caring may not always become a part of the lived experience of the program. When asked, participants in this study were challenged to recall direct learning about caring, that is a conversation, a lecture, or a course in which caring was referred to as caring and connected in some way to their formal learning experience. Participants described more of an independent reflective process in which they connected caring to what they were learning.

Courses that participants recalled, in this study, to be most helpful in learning caring were those that highlighted the holistic needs of patients and how students could address those needs. Courses that had a direct connection to nursing, facilitated learning caring for participants of this study. If a course was focused on content within the context of nursing, learning caring was facilitated. Online (Sitzman, 2010; Sitzman & Leners, 2006) and lab settings (Minnesota Baccalaureate Psychomotor Skills Faculty Group, 2008) were supported by research as important nursing education settings in which to learn caring. For participants in this study the classroom (Adamski et al., 2009; Lee-Hsieh et al. 2007; Stowe, 2006) and clinical settings (Hwang et al., 2013; Lindberg et al., 2012; Porr & Egan, 2013) were most influential in learning caring, however the clinical setting had a much more profound impact on learning caring. Porr and Egan (2013) reported that caring in the practice setting was enhanced when Faculty members had a means to evaluate students' caring abilities.

Learning caring for participants in this study was facilitated by instructional methods such as reflection, discussion, and role modeling. In the literature, some nursing students learned caring through creative learning modes such as writing, aesthetic projects, and reflection (Drumm, 2006; Drumm, & Chase, 2010). Although participants in this study did not mention writing and aesthetic projects, reflection was an important instructional method to learn caring. Researchers have reported other instructional methods that facilitated learning caring, which included but were not limited to discussions, journaling, simulations, readings, and involved students' applying caring skills and concepts outside the classroom setting (Lee-Hsieh et al., 2007; Stowe, 2006).

It is suggested in the existing research, a course that specifically refers to caring in an intentional and direct way is a facilitating factor for learning caring (Lee-Hsieh et al., 2007; Stowe, 2006; Wu et al., 2009). Prior to 2001, a course did exist in the curriculum of interest entitled Caring Relationships that was part of the BN program, however, the course title and focus were changed from caring to professional and helping relationships with a focus on communication. An omission of a caring course in a nursing education program might lead to the omission of caring in the lived experience of the program. This presents an opportunity to revisit and redefine or reinforce the roots of the program including the philosophical underpinnings such as caring. Even though a course specifically focused on caring does not exist in this curriculum, it is important to note that caring is present in the curriculum in indirect ways, for example through the language of communication and social justice. In addition, as outlined in Table 7, there is a course in first year, N1032, that focuses on caring through the language of building professional relationships.

Faculty ought to give intentional thought to how caring is defined and how it appears in nursing and non-nursing courses. Caring for participants in this study is an overarching philosophy and a professional imperative that is holistic, personalized, communication and action oriented, and impacts all nursing including nursing education. For participants their meaning of caring was often embodied through communication and social justice, which is reflective of how caring is represented in curriculum documents that directly inform course design and instructional methods (i.e. course blueprints). In those documents caring is described using communication and social justice language. Although caring is not mentioned in the outcomes of professional identity, participants shared about the importance of caring to their professional identity. Participants connected their responsibility to be caring as part of their roles as nursing students.

The provision of tools to embody caring in the clinical setting was also an external facilitating factor for learning caring. Participants needed to be provided with and supported to use tangible tools to embody caring in the clinical setting. Many authors concluded that nursing students felt more equipped and supported to care for patients in the practice setting when they had the right tools and when faculty members were caring with them (Labrague et al., 2015; Livsey, 2009; MacNeil & Evans, 2005). Clinical instructors were identified as having a major impact as role models because their caring with patients and students could influence the whole learning experience (Eskilsson et al., 2014; Kosowski, 1993, 1995). For participants in this study being cared for as students meant being understood, supported, and respected. When faculty role modeled caring with patients, students felt more motivated and empowered to embody caring with patients. Caring begot caring.

Feedback from patients and nurse educators was also described as an external factor that facilitated learning caring. For participants of this current study, feedback from patients often occurred through verbal means, but it also occurred through non-verbal means. Solvoll and Hegen (2010) agree that feedback is important and suggest that if opportunities for dialogue were not provided in practice and instead there was a focus on tasks and problem solving, students might be left to learn caring on their own (Solvoll & Heggen, 2010). Feedback was facilitated when the nursing supervisor created an open and secure atmosphere in which to learn caring (Eskilsson et al., 2014).

Uncaring encounters, another external facilitating factor, was also described by participants in this study as a limiting factor in learning caring. The facilitating nature of uncaring encounters typically depends on the participants' responses to the encounter. As an external facilitating factor for learning caring, uncaring encounters reminded participants of the type of nurse they did not want to become. This experience was then used to develop participants' meaning and embodiment of caring. This finding was echoed in the literature (Kosowski, 1993, 1995; Ma et al., 2014).

Factors that Limited Learning Caring

In addition to facilitating factors, factors also existed that limited learning caring. Although hesitant, participants were able to articulate what in their lived education experience, limited their learning caring. Both participants in this study identified internal and external limiting factors that were consistent with those limiting factors described in the caring literature. For participants in this study, factors that limited learning caring included a lack of direct discussion about caring, courses that were fact focused without a nursing lens, courses that were combined with non-nursing students, an increase in the number of complex psychomotor skills, nurses and nurse educators

who were uncaring, burnout, and a lack of self care. These factors will be discussed individually.

Lack of direct discussion about caring was identified as a limiting factor for participants of this study. When asked, participants could not recall a time in their nursing education in which caring was identified directly as caring. Participants recalled making the connection to caring on their own in classroom and clinical courses. This may be a reflection of a lack of direct caring language in curriculum documents that were explored as part of this study (i.e. course blueprints), which directly inform course design and instructional methods. It may also be a reflection of a need for increased support for faculty members to teach caring. In one study, if faculty members were not encouraged or prepared to teach caring, caring was viewed as someone else's responsibility such as registered nurses and preceptors in the practice setting (Lindberg et al., 2012). However, based on their work, Lindberg et al. (2012) suggested that nurses in the practice setting, including registered nurses, senior preceptors, and head nurses viewed teaching caring as the responsibility of faculty members, thus creating a gap in which students were left to learn caring independently. As participants of this present study pointed out, if individual students do not have the motivation to *pick up* caring on their own, learning caring may be lost. It is important to note that, despite not recalling a direct discussion about caring, many of the ways that participants described the meaning of caring are consistent with the core program abilities and related outcomes (i.e. communication, professional identity, and social justice).

For participants of this study, courses that were fact focused, without a nursing lens, and courses that were combined with non-nursing students acted as limiting factors for learning caring. Participants felt that large enrollment courses such as science

courses, for example anatomy and physiology, should have a direct connection to nursing that includes caring. That raises the question, should non-nursing science academics and/or registered nurse academics teach science to nursing students? An option might be collaboration between the two in the development and delivery of mandatory science courses in the BN program (Birks, Ralph, Cant, Chun Tie, & Hillman, 2018). To meet the unique needs of nursing students, Borges and Mello-Carpes (2014) recommended that seminars be implemented concurrently with science courses, that contextualize science content for nursing.

Another external limiting factor was an increase in the number of complex psychomotor skills. Participants in this study reflected a lot on psychomotor skills or hands on nursing skills. They felt being competent with psychomotor skills was an essential component of caring, while at the same time they described complex hands on skills as a limiting factor for learning caring. Participants explained that when their attention was focused on mastering a task, they could not simultaneously focus on caring for the patient's mental and emotional needs. This echoes Benner's (1984) findings in the theory, *From Novice to Expert*, in which a novice nurse experiences challenges to focus on the bigger picture of patient care needs. Instead their learning tends to be focused on a smaller piece of the bigger picture. With this particular example, the student's focus would be on the physical task at hand, without a well-developed ability to focus beyond the task. That is, when a student is focused on mastering hands on skills, they are often not able to focus on anything else, for example talking to the patient. The participants did not articulate how complicated hands on nursing skills can and should be caring in terms of the nurse's approach when completing psychomotor skills. Instead participants reflected on competence being integral to caring, but they did

not make the reverse connection of caring being integral to competence. The Minnesota Baccalaureate Psychomotor Skills Faculty Group (2008) explained that a focus on psychomotor skills without caring might take away from the humanness of nursing and reduce the patient to a diagnosis. They suggested that psychomotor skills must be taught in a caring manner; that is caring must be integrated in the nursing lab setting (Minnesota Baccalaureate Psychomotor Skills Faculty Group, 2008). Participants of this present study reflected on the importance of psychomotor skills in measuring nurses' competence. In one study, nurses felt their competence was often measured by their skill at completing complicated procedures instead of their ability to be caring with someone in the moment (Engebretson, 2000). With a focus on complicated procedures, a future orientation to time and valuing material over immaterial resources health care organizational values can also limit learning caring (Engebretson, 2000). Participants of this present study did not identify organizational values as a limiting factor for learning caring.

Another factor that limited learning caring for participants of this present study were nurses and nurse educators who were uncaring. In the existing literature, if caring was not intentionally integrated in nursing education, it was possible, that the education experience could decrease students' caring abilities (Ma et al., 2014; Murphy et al., 2009). In order to integrate caring into the education experience, nurses and nurse educators need clear guidance on how to integrate caring into teaching. Although they did not provide one particular definition of caring in their study, Ma et al., (2014) concluded that nursing students' learning needs might be met through integrating into nursing education a *...formal curriculum concerning caring science, caring knowledge, skills, attitudes and the art of caring...* (p. 8). In addition, Ma et al. (2014) suggested

that ...*the informal and hidden curricula such as role modeling, reflective practice, critical thinking and conducive learning environment play an important role in learning about caring* (p. 8). If caring is not integrated into the education program, Murphy et al. (2009) suggested that nursing students may experience occupational socialization and/or dissonance. Occupational socialization was the process by which nursing students internalized the beliefs and values of the nursing culture (Murphy et al., 2009) and dissonance was experienced when students' caring ideals were tempered by the real life challenges of nursing practice (Murphy et al., 2009). As mentioned above, uncaring encounters, if not reversed (Kosowski, 1993, 1995), left participants feeling tension, fear, and intimidation. Participants explained that when these feelings were present for them, they avoided asking questions or engaging in discussion with the nurse and/or nurse educator.

One participant of this present study highlighted the impact of burnout on nurses' and nurse educators' ability to care and how that may have a direct impact on their own learning caring. Another participant identified a lack of self-care as a limiting factor for learning caring. Nursing students and nurses want to be caring, but not at the expense of their own wellbeing (Sumner, 2008). One participant explained that a nurse must take care of their own mind, body, and spirit to effectively care for others. For nurses in Sumner's (2008) study, organizational constraints such as a lack of time and lack of human and physical resources made caring feel impossible or even discouraged, which may cause a value conflict or dissonance for nurses and nursing students alike. Value conflicts often caused nurses to experience contradictions and tension, which the authors suggested, could lead to apathy and burnout (Kahn & Steeves, 1988; Sumner, 2008). Sitzman (2017) reminds us that self-care is necessary to mitigate the emotional strain of

nursing and provides theory based self-care activities that nurses and nursing students can engage in.

What This Study Adds to the Existing Literature

This study has enhanced and developed the existing learning caring literature. In particular, this study adds an in-depth analysis of curriculum documents. This study also situates learning caring within facilitating and/or limiting internal and external factors that influence caring. In addition this study situates learning caring within van Manen's (1997) phenomenological research method including temporality, corporality, and relationality. Also, in keeping with van Manen's (1997) methodology, the study provides a strong pedagogical orientation to learning caring in nursing education. The study enhances the present learning caring literature by highlighting learning caring as a holistic experience that requires nursing students to take risks. Following is an in-depth discussion of what this study adds to the existing learning caring literature.

This study is novel in that curriculum documents were analyzed for the absence and presence of caring language. It was found that concurrent curriculum analysis with lived experiences of nursing students is invaluable in considering context and the impact of curricular values. The findings from this study support that curriculum documents must undergo reflection and revision on a consistent basis to stay recent and representative.

This study situates learning caring within the context of internal and external factors that facilitate and/or limit learning caring. Internal factors include, for example, the notion that participants came to nursing with established caring values and a caring identity that stemmed from experiences with family and friends. External factors occur,

in part, prior to nursing through experiences with family and friends and through the nursing education experience.

This study also situates the phenomenon of learning caring within the context of van Manen's (1997) method of phenomenological research. In terms of this particular methodology, learning caring is described and interpreted within the context of the lived experience including temporality, corporality, and relationality. Temporality, corporality, and relationality are discussed in detail earlier in this chapter. Spatiality, one of the four components of the lived experience, is not included in the discussion because it did not arise from the data. Spatiality refers to the lived space (van Manen, 1997) and involves the physical space including size and location. In terms of learning caring, the physical space may include the clinical or classroom settings; however, participants in this study did not recall the lived space or spatiality in terms of their experience; therefore it is not discussed here.

Also, in keeping with van Manen's (1997) research method, this study adds a strong pedagogical orientation to the phenomenon learning caring. This study resulted in a number of pedagogical implications, which are discussed in more detail in Chapter six (Implications and Conclusions). During data collection and analysis it was noted that nursing students' lived experiences add a valuable perspective to the pedagogy of caring in nursing. In particular, participants shared valuable ideas about course design and instructional methods that facilitated and limited their learning. Nursing students' contributions to the pedagogy of nursing and caring in nursing is not reflected in the existing learning caring literature. This gap points to a need to replicate this study to learn more from nursing students about how to enhance the pedagogy of caring.

In terms of the phenomenon learning caring as lived by nursing students in a four year BN program, a number of novel findings arose from data analysis in this study. New findings included embodiment of caring that requires holistic learning; learning that involves the mind, body, and spirit. Part of the holism of learning caring is the need for self-care. The purpose of self-care in learning caring is twofold. First, by engaging in self-care activities nursing students can promote their own wellbeing. Second, the specific self-care activities, such as mindfulness and relaxation, can directly impact learning caring by bridging the gap between physical or practical learning (embodiment of caring) and cognitive learning (transformation in their meaning of caring).

Another novel finding that this study adds to the existing learning caring literature is the risks involved in learning caring; in particular the embodiment of caring. Embodiment of caring involved learning that others, such as patients, nurses educators, and nurses could see and observe. Participants spoke about feeling hesitant and vulnerable in embodying caring in the clinical setting. For participants this seemed to stem from a lack of self-confidence in their caring competence. Participants voiced a fear of doing or saying the wrong thing. Once the risk was taken, or caring was embodied, participants experienced significant learning as evidenced in critical learning turning points discussed in Chapter four (Findings).

Limitations

Although this study adds valuable data to the existing literature it is important to note limitations inherent in the study. Five limitations have been identified. The limitations include a small sample size, the possibility that this type of study may only appeal to participants who value caring, interviewing only fourth year students, not

interviewing faculty who develop(ed) and implement(ed) the curriculum, and conducting only one member check interview.

It must be noted that this study was conducted with a small sample size due to lack of participation given the time constraints of the thesis process. So, even though each of the participants' lived experiences are significant and add to the knowledge about learning caring, the findings cannot be generalized, which is in keeping with van Manen's (1997) research methodology. In addition, with a small sample size, the interview questions may not be as thorough as possible. This is because as interviews were conducted the interview guide was refined. More interviews would create more opportunities to refine the interview guide.

The second limitation is the possibility that only participants who value caring were recruited for this study. This is a limitation because it excludes an important perspective from a group of people who may not value caring in nursing. This limitation requires further exploration to ensure more diverse perspectives are represented in the learning caring literature.

The third limitation is interviewing only fourth year students. It is possible that, because they are fourth year students, they are more aware of learning caring in fourth year. The fourth year experience is the most recent experience in their memories. Is it possible that nursing students in each year of the BN program would describe learning caring in some way?

The fourth limitation is not interviewing faculty who developed and implement(ed) the curriculum. Without their experience it is impossible to understand the curriculum documents completely. Faculty who have developed and implement(ed)

the curriculum could provide their lived experience of developing the curriculum, which is important to understand the phenomenon of teaching and learning caring.

To enhance the trustworthiness of this study, one member check interview has been conducted. The data gained from one member check interview has enhanced the findings and discussion of this study; however, it would have been ideal to conduct a member check interview with each participant.

Chapter 6: Implications, Recommendations, and Conclusion

It is important to think about implications of this study within the context of nursing education, education administration, practice, and research. As you will see there is a considerable focus on nursing education throughout the implications of this study. Given the pedagogical orientation of this study a focus on pedagogy makes sense and is in line with van Manen's (1997) research method. For that reason, nursing education also appears in the practice, administration, and research implications of this study.

Education

There are a number of education implications for this study. Education implications can be divided into two categories including implications related to curriculum documents and implications related to the lived experience. Implications related to curriculum documents include the use of a specific definition of caring, the consistent use of caring language throughout the documents, and tracking and archiving shifts in the curriculum including document changes. Implications related to the lived experience include entry requirements to nursing, caring in nursing and non-nursing courses, instructional methods, assessment tools, and nurse educators.

In terms of implications related to caring in curriculum documents, it is important for a clear definition or definitions of caring to be present that directly impact course design and instructional methods. To inform the curricular meaning of caring, it is important to reflect on a number of definitions of caring. How does the faculty of interest want to define caring? Should there be one or more specific definition(s) of caring that guide(s) the curriculum? How can the definition of caring be more explicit and expanded so that nurse educators and nursing students have a language with which

to talk about caring? It would be valuable to include past and present nursing students in these conversations. This way the lived experience of the curriculum, from their perspective, can be included in the discussions and decisions about curriculum ideas and changes.

There are many nursing theories of caring from which to draw inspiration such as Boykin and Shoenhofer (2013), Leininger (1991), Sumner and Fisher (2008), Swanson (1991, 1993), Watson (1988, 2008, 2009a,b), Watson and Smith (2002). In the curriculum documents of interest, specifically the course blueprints, caring is defined indirectly using language related to communication and social justice. These two ideas play a major role in the presence of caring language in these documents. Should this connection be made more explicit? How can this meaning of caring inform the definition of caring in the seminal curriculum documents?

A clear definition of caring is not present in the curriculum documents included in this analysis. It is important to note that one nursing caring theory was referenced in the seminal curriculum documents, which was Leininger's (1991) theory of transcultural nursing. In addition, the textbook *Toward a Caring Curriculum: A New Pedagogy for Nursing*, by Em Bevis and Jean Watson (1989) was used to support curriculum design not directly related to caring. Whether or not the faculty members value these theories or others, it might be beneficial to thread theoretical knowledge more consistently throughout the curriculum and have faculty development sessions focused on how to integrate the theoretical knowledge in tangible ways in the classroom, lab, and clinical settings. As well, use of up-to-date renditions of the theories of caring should be utilized and recorded.

When course blueprints were compared to older, seminal curriculum documents, such as *The Big Picture* document and the *BN Program Abilities Leveled Outcomes* document (see Table 1), caring language appears much less in the blueprint documents, which are much more recent. One might ask the question, whether or not seminal curriculum documents are considered when updating more recent curriculum documents? This calls for a need to revisit all the curriculum documents, including the resources supporting those documents, as a faculty and rethink how the philosophical underpinnings are represented. This would support evidence based practice by ensuring seminal curriculum documents are supported by recent research. Discussions about caring, social justice, and primary health care would be included in this activity.

The presence of caring language diminishes as you move away from the philosophical underpinnings in *The Big Picture* document and move towards the program abilities and outcomes that directly guide course design and instructional methods. This can perpetuate a gap between the theoretical component of caring and the lived experience of learning caring in nursing education. It is interesting that while the abilities framework does not include caring language, much of what participants talked about in terms of their meaning of caring is consistent with the language used in the program abilities and related outcomes (e.g. communication and social justice/effective citizenship).

Caring is present most often in the abilities of communication and social justice and does not appear at all in the outcomes of critical thinking or professional identity. In addition, caring appears least in year four with only one outcome in five courses and 26 credit hours, containing the word caring. It is evident that there is an imbalance between philosophical underpinnings in how they appear in the abilities and outcomes language.

An even distribution or threading of each philosophical underpinning throughout the curriculum would be beneficial. This could happen through faculty and student reflection and discussion about the big picture curriculum.

Caring does not appear as part of the leveled learning outcomes for critical thinking and professional identity. This finding is concerning because caring is complex and requires from nurses a great amount of skill to implement into practice. In addition, given the important nature of caring in the nursing profession, it is interesting to find that caring is not included in learning outcomes related to professional identity. This is interesting because participants identified with caring as a professional imperative when they recalled making the connection between their professional and caring identities. What might happen if nursing students cannot or do not connect their professional identity with caring? It is possible that in the absence of a connection caring may be lost.

It is also important to note an inconsistent use of language to identify the three philosophical underpinnings of the curriculum, primary health care, social justice, and caring. For example the three underpinnings are simultaneously referred to as principles in the *Faculty of Nursing Vision, Mission, and Values* document and as philosophical underpinnings and foundations in *The Big Picture* document. A lack of congruency in the language used to identify primary health care, social justice, and caring can exacerbate confusion around the meaning of these ideas. A clear and consistent approach to identify these important terms is necessary to facilitate learning about each underpinning and how each applies to practice as a nurse.

Tracking and archiving shifts in the curriculum, including changes in documents, could help facilitate access to and use of the documents when making curriculum

decisions. This may facilitate a well-informed and dynamic curriculum that is built on previous and present knowledge and experience. Now that curriculum documents are stored primarily in electronic forms, this may no longer be a consideration; however in retrospect, it would have been helpful to have a universal means to track and archive curriculum changes including changes to curriculum documents.

The curriculum documents should facilitate the lived experience of learning caring in the education experience. There is an opportunity to make a direct connection between curriculum documents and the lived experience of the curriculum. Given the importance of caring in the seminal documents of this curriculum and in the existing research literature, the presence of caring language should be balanced in learning outcomes across each year of the BN program. If caring is not present, for example, in the fourth year curriculum, nurse educators may not be prompted to include caring in course design and instructional methods, which may mean that caring does not translate into the lived experience of the BN program, possibly resulting in some nursing students not experiencing what participants called a *wake up call* or a realization of their transformation. This may be a missed opportunity to learn caring.

In addition to threading caring language throughout the curriculum documents, faculty could explore the addition of a course in the first year of the BN program that is focused on caring. This would provide foundational knowledge related to caring in nursing and a beginning language with which students and nurse educators could talk about caring. By including the course in the first year curriculum, the conversation about caring can start early in the BN program, which is something participants in this study thought was important.

When reflecting on learning caring and the factors that facilitate and/or limit learning caring, an implication for entry to a BN program might include the use of a quantitative research instrument that measures caring behaviours and/or caring abilities as part of the screening process. This might help faculty members gauge whether or not an applicant values caring, which might facilitate the process of learning caring for the applicant. It would also add a quantitative method to support the qualitative essay method or life sketch that is often required for entry to a BN program

It is evident from this study and literature, that faculty members and nurse educators are ideally situated to teach caring and promote the pedagogy of caring in nursing education. Part of this is their role in developing, implementing, and evaluating nursing curricula. For that reason it is important for faculty members to have support to further develop caring in the curriculum documents and lived experience.

As mentioned above, caring within course blueprints is described using language related to communication and social justice. Sumner and Fisher (2008) offer a middle range theory that is testable and measurable entitled *The Moral Imperative of Caring as Communicative Action*. The theory has a strong focus on communication as caring.

Given that learning caring includes the embodiment of caring, the meaning of caring in the curriculum documents need to be applicable to nursing practice. To facilitate the transfer of learning for nursing students, instructional methods should pull together the gap between theory and practice. When learning caring, the mind and body need to be connected, especially in the clinical setting. Mindfulness exercises and journaling are helpful activities that can also be self-care strategies, to help students connect physical and cognitive learning (Mathew et al., 2014). This could be achieved through course design and instructional methods that provide nursing students with

tangible tools to embody caring. Instructional methods might include self-care strategies, reflection, discussion, and critical thinking about caring.

The embodiment of caring in clinical might also be enhanced if nurse educators have a means to assess students' caring abilities. Porr and Egan (2013) identify caring ability through intentionality, relationality, and responsivity. With their assessment tool, the Caring Interactions Inventory, the use of caring language can facilitate open and direct discussion about caring by providing faculty, nurses, and nursing students a language with which to talk about caring in nursing practice. Given that we know there were risks involved with embodying caring for participants of this study, having a language with which to talk about caring might encourage nursing students to experiment with caring methods, which is necessary for learning caring.

As highlighted by this study, non-nursing courses can act as limiting factors for learning caring. In an effort to contextualize general knowledge from non-nursing courses such as anatomy and physiology, collaboration between science academics and nursing academics might be beneficial. This could be in the form of seminars that contextualize science content to meet the needs of nursing students in their future professional roles as nurses (Borges & Mello-Carpes, 2014).

Given that nursing is a practice based profession that includes a multitude of complex psychomotor skills, it is essential to include caring in the teaching of those skills (Minnesota Baccalaureate Psychomotor Skills Faculty Group, 2008). Participants in this study felt being competent with psychomotor skills was an essential component of caring, while at the same time psychomotor skills acted as a limiting factor for learning caring. This paradox could create dissonance for nursing students. To resolve the dissonance and to facilitate learning caring, the Minnesota Baccalaureate

Psychomotor Skills Faculty Group (2008), suggested that psychomotor skills be taught in a caring manner - caring must be integrated in the nursing lab setting. This might help nursing students bridge the gap between physical and cognitive learning. Also, considering Benner's (1984) theory *From Novice to Expert*, helping students perform psychomotor skills in a caring manner will help them develop their sense of the patient's lived experience, taking their focus from the technical minutia to the broader implications of completing psychomotor skills using caring behaviours.

Nursing Education Administration

Based on the finding that caring begets caring, nursing education administration or those in leadership roles in nursing education need to live caring. It is reasonable to think that if nursing students' caring is enhanced through being cared for, it may be the same for faculty members. That is if faculty members feel cared for by those in nursing education administration positions, they may experience an enhanced ability or desire to care for others and themselves. Also, given the importance of self care in caring and learning caring, nursing education administration can support the development, implementation, and evaluation of an infrastructure for self care activities for faculty members and nursing students.

Faculty members and students also need encouragement and support to engage in big picture thinking about the curriculum to ensure the curriculum as a whole is considered when making decisions about its individual parts. As part of a big picture curriculum discussion, faculty members need support to have discussions about the language used to organize the curriculum including how the language might impact the lived experience of the curriculum. This can be done through providing and supporting an infrastructure for faculty development sessions, discussion, reflection, brainstorming

sessions, focus groups, interviews, etc. Connecting faculty and students in these activities. This might facilitate teaching caring for faculty members and learning caring for nursing students.

To support faculty and students alike, action oriented means to implement caring in practice should be present in the curriculum documents and faculty could be provided with professional development sessions that explore caring and teaching caring. Professional development for faculty and nurse educators might also include sessions on how to integrate curriculum philosophical underpinnings and values, such as caring, into course design and instructional methods.

Practice

The term practice can have different meanings for nurses. When considering the term, practice, it can mean the traditional nursing settings such as hospitals, clinics, and communities or it could mean practice in a broader sense in which nurse educators' practice might be just as much teaching as it is nursing. For the purpose of explaining practice implications, I have considered the practice setting for nurse educators to be teaching in the clinical setting. This is in part due to the importance of the clinical setting in learning caring. The teaching environment, in general, is discussed as part of education implications. This way nurse educators' experiences of bridging two worlds in the clinical setting - theory and practice - is acknowledged.

Although caring as a value in the curriculum is meant to guide all faculty interactions, how to incorporate caring into interactions is not as clear. This is important because if faculty members do not embody caring, nursing students may not have the necessary role models needed for learning caring. Findings from this study suggest that caring in curriculum documents needs to be practical and pedagogically oriented. A

way to support the embodiment of caring in practice is to have faculty development sessions that reintroduce caring as it is applied in practice. Faculty development sessions about embodying caring would also support the advancement of a caring pedagogy.

It is important to consider how curriculum documents support course designs and instructional methods that bridge the gap between caring theory and caring practice. Questions to consider are, how can the meaning of caring in curriculum documents guide learning caring that involves a transformation in the meaning of caring and embodiment of caring? How can faculty help students be present in their bodies and minds when learning caring? How can faculty members be supported to facilitate learning caring? Sitzman and Watson's (2018) text *Caring Science, Mindful Practice. Implementing Watson's Human Caring Theory* is an excellent resource for integrating caring in teaching and learning within nursing education.

Given that learning caring involves the embodiment of caring, through course design and instructional methods, it could be helpful for nursing students to be provided with and encouraged to use tools to embody caring in the clinical setting. For faculty members and nursing students alike there should be a means to develop, implement, and maintain caring relationships in nursing practice. To support faculty and students, action oriented means to implement caring in practice could be present in the curriculum documents. In addition, nurse educators and faculty members need a means to evaluate caring. Caring is often embodied in the clinical setting therefore the clinical setting provides a great opportunity to call forth and assess caring abilities.

Nurse educators and nurses play integral roles in facilitating learning caring in the clinical setting. Given that the embodiment of caring often takes place in the clinical

setting, the implementation of tools to embody caring need to be facilitated there. Given the important nature of nurses and nurse educators as role models it is critical that nurses and nurse educators collaborate to facilitate the lived experience of learning caring. A definition of caring and a tool to measure caring abilities could facilitate the collaboration. This might also facilitate a closer connection between course outcomes and the lived experience. It may also help preceptors and nurse managers better understand caring and integrate professional development sessions that help close the gap between caring theory and practice.

Research

When conducting this study, many subsequent questions arose about learning caring. Those questions included:

- Is caring hereditary? Genetic?
- Can learning caring only occur for nursing students who identify as caring prior to nursing?
- What if students come from an uncaring family?
- What is the lived experience of learning caring for nursing students who do not value caring?
- How might potential students' caring values be assessed?
- How do we nurture learning caring in nursing education?
- Are there other internal factors that limit learning caring? If so, how do we get at that internal lived experience?
- Should a non-nursing academic and/or a registered nurse academic teach science to nursing students?

- Does the physical structure of the organizational setting of clinical facilitate and/or limit learning caring?
- What is the meaning of teaching caring for nurse educators and faculty members within a faculty of nursing?

The majority of research about nursing students' lived experiences of learning caring is qualitative because it is a topic that lends itself well to a qualitative approach. In particular phenomenology has been used most frequently. However there is a need for researchers to engage in more quantitative research. Quantitative research might facilitate knowledge development around the financial impact of caring or the impact caring has on morbidity and mortality of patients. It would be a good idea to replicate this study to learn more from nursing students about how to enhance the pedagogy of caring in nursing education. There also seems to be a need to explore, through research, specific course designs, and instructional methods that limit and/or facilitate learning caring.

Conclusion

Participants in this study made valuable contributions towards the pedagogy of learning caring. Participants reminded us that learning caring is a complex human phenomenon that requires nurturing throughout the entire nursing education experience. Curriculum documents are also integral to the pedagogy of caring in nursing. To nurture learning caring, caring must be supported in both the curriculum documents and the lived experience of the program. Nursing Faculty members at all levels of academia need to be responsible to ensure caring is intentionally present in curricula. To take responsibility, nurses and nurse educators must be supported through tangible means to enhance the pedagogy of caring in nursing.

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Appendix A

Search and Results for each Database

Database	Search	Results	Relevant articles
CINAHL	("nursing student*" OR "nursing student*" OR "undergraduate nurse*" "students, nursing") AND (learning OR education OR teaching) AND caring	n = 884	n = 9
Medline	("nursing student*" OR "nursing student*" OR "undergraduate nurse*") AND (learning OR education OR teaching) AND (caring OR empathy)	n = 658	n =2
ERIC	("nursing student*" OR "nursing student*" OR "undergraduate nurse*" OR "nursing education") AND (learning OR education OR teaching) AND caring	n = 129	n = 0

Appendix B

Reflective Journal Guide

Pre-reflective Entry

1. How will I care for this student participant during the interview process?
2. How will my approach with this student participant benefit or not benefit them?

Post-reflective Entry

1. How might my experience as a nursing student, nurse, and nurse educator impact my analysis of this interview?
2. How does this student participant's experience represent learning caring?
3. What has it been like for this student participant to learn caring?
4. What is the meaning of learning caring for this student participant?
5. How can the student participants' experiences of learning caring impact the pedagogy of learning caring in nursing education?
6. What was the student participant's demeanor and body language during this interview?

Note: Further prompts may be necessary to clarify experiences and ideas.

Appendix C

Original Interview Guide

- For you, what is the meaning of caring in nursing?
 - Can you provide an example?
 - How does this meaning fit with your experience of learning caring?
- How was caring integrated into your nursing education experience?
- How was caring missing from your nursing education experience?
- Tell me about a time in your nursing education when you learned caring.
- How were you feeling during that experience?
- What made this experience a meaningful caring experience?
- What made this experience a meaningful learning experience?
- Did this experience influence your future nursing actions? If so, how?
- What about your education experience has promoted your learning caring?
- What about your education experience has made it challenging for you to learn caring?
- Tell me about a time in your nursing education when you experienced an uncaring moment.
 - How did that moment impact you?
 - Did that experience influence your future nursing actions? If so, how?
- What else would you like to share with me about your experience of learning caring?

Note: Further prompts may be necessary to clarify experiences and ideas.

Appendix D

Revised Interview Guide

- What made you want to be a participant in this study?
- For you, what is the meaning of caring in nursing?
 - Can you provide an example?
 - How does this meaning fit with your experience of learning caring?
- How was caring integrated into your nursing education experience?
 - Can you recall specific courses in which you learned caring?
- How was caring missing from your nursing education experience?
- Tell me about a time in your nursing education when you learned caring.
- How were you feeling during that experience?
- What made this experience a meaningful caring experience?
- What made this experience a meaningful learning experience?
- Did this experience influence your future nursing actions? If so, how?
- What about your education experience has promoted your learning caring?
- What about your education experience has made it challenging for you to learn caring?
- Tell me about a time in your nursing education when you experienced an uncaring moment.
 - How did that moment impact you?
 - Did that experience influence your future nursing actions? If so, how?
- What else would you like to share with me about your experience of learning caring?

Note: Further prompts may be necessary to clarify experiences and ideas.

Appendix E

Proposed Research Timeline

Date	Activities
August 2017	<ul style="list-style-type: none">• Proposal Discussion August 29, 2017• Submit project for ethics review
September 2017- December 2017	Once Ethics approval is obtained: <ul style="list-style-type: none">• Active recruitment (Visiting students, Facebook, course D2L homepage, email, University homepage [news and events])• Anticipate most interviews (2-3) will be completed by the middle to end of December• Biweekly meeting with supervisor to address progress and areas of concern• Revise interview process/format as necessary• On-going interviews, transcription, and data analysis• On-going thesis writing
January 2018	<ul style="list-style-type: none">• Complete thesis writing• Member check interviews• By-weekly meetings with supervisor• Send Master's thesis to internal reader (3-4 weeks for response)
February 2018	<ul style="list-style-type: none">• Send Master's thesis to external reader (3-4 weeks for response)
March 2018- April 2018	<ul style="list-style-type: none">• Thesis discussion• Submit thesis documents• Submit findings for publication to reputable journal(s)

Appendix F

Revised Research Timeline

Date	Activities
August 2017- November 2017	<ul style="list-style-type: none">• Proposal Discussion August 29, 2017• Ethics application submitted to Fredericton Faculty of Nursing (FON) Ethics Committee August 31, 2017• Proposal Received from FON Ethics Committee chair on September 17, 2017 with edit suggestions• Edited ethics application resubmitted to FON Ethics Committee September 26, 2017• Ethics approval received from FON Ethics Committee on September 28, 2017• Ethics application submitted to University of New Brunswick (UNB), Fredericton Research Ethics Board (REB) October 11, 2017• Proposal received from UNB Fredericton REB chair on October 14, 2017 with edit suggestions• Edited ethics application resubmitted October 16, 2017• Ethics application approval from UNB Fredericton REB received on October 17, 2017• Ethics application and Ethics approval letter from UNB Fredericton ethics committee sent to UNB Saint John REB on October 19, 2017• Ethics approval received from UNB Saint John REB on November 6, 2017
November 2017	<ul style="list-style-type: none">• Contact made with Faculty of Nursing department chair on November 13, 2017• Response received from department chair on November 20, 2017 with concerns, a request for specific research documents, and a note that my research supervisor would be contacted• Requested documents sent to department chair on November 23 2017 and to the Dean of the Faculty of Nursing on November 24, 2017• Approval email received from the Dean of the FON on November 28, 2017

November 2017- May 2018	<ul style="list-style-type: none"> • Active recruitment of participants began November 29, 2017 (Posters, visiting students, Facebook, course D2L homepage, and email) and continues to present (March 2018) • Two participant interviews completed as of January 30, 2018 • Active collection of curriculum documents began November 29, 2017 and continues to present (March 2018) • Available curriculum documents obtained between December 2017 – February 2018 • Bi-weekly to monthly meetings with committee to address progress and areas of concern • On-going data analysis • On-going thesis writing • Submit Methodology Chapter by April 15, 2018 • Submit Findings Chapter by April 30, 2018 • Submit Discussion Chapter by May 15, 2018 • Submit Recommendations/conclusions Chapter by May 30, 2018 • Member check interviews (one in July 2018)
April 2018 – July 2018	<ul style="list-style-type: none"> • Baby due April 29, 2018 • Complete thesis writing • By-weekly meetings with supervisor • Send Master’s thesis to internal reader no later than June 8, 2018 (3-4 weeks for response)
July 2018 – August 2018	<ul style="list-style-type: none"> • Send Master’s thesis to external reader no later than July 6, 2018 (3-4 weeks for response)
September 1, 2018	<ul style="list-style-type: none"> • Last day to apply online to graduate at Fall Convocation 2018 (pending submission of all degree requirements)
September 3-13, 2018	<ul style="list-style-type: none"> • Submission of corrected thesis document • Thesis discussion
September 14, 2018	<ul style="list-style-type: none"> • Last day to submit degree requirements including discussion and corrected thesis to the Dean of Graduate Studies
October 18, 2018	<ul style="list-style-type: none"> • Fall Convocation
October 2018- December 2018	<ul style="list-style-type: none"> • Submit findings for publication to reputable journal(s)

Appendix G

Information Sheet and Certificate of Informed Consent

Part 1: Information Sheet

My name is Amy Carrier Fanjoy. I am a graduate student in the Masters of Nursing program at UNB Fredericton. I am doing research about nursing students' experiences of learning caring.

What is the purpose of this research?

The purpose of this research is to answer one main question and four sub questions. The main question is, "what is it like for nursing students to learn caring in a curriculum that has caring as a core value?" The four sub questions are:

- What is the meaning of caring for nursing students?
- What is the meaning of learning caring for nursing students?
- What are factors within nursing education that facilitate and/or limit learning caring for nursing students?
- From the nursing students' perspectives, how is caring lived within a curriculum that has caring as a core value?

What is expected of you?

If you take part in this study you will be asked to complete two interviews (about one hour each) with me at locations of your choice. They will be digitally recorded.

Your involvement in this research is voluntary. It is your choice whether to participate or not. Your choice will not impact your grades or status as a nursing student. You may at any time change your mind and stop taking part even if you agreed earlier.

What are the risks and benefits of your participation?

There are no expected risks with this research. If at any time you feel uncomfortable during the interview process, the interview can stop. During the interview you can choose not to answer a question or questions. If you choose not to answer a question or questions or if you choose to stop the interview your grades or status as a nursing student will not be affected. The benefits for you are to influence caring in nursing education and a chance to win a Super Store gift card. You may also benefit from sharing, debriefing, and reflecting on your experience.

How will I maintain your confidentiality?

It is your choice whether or not to share your experience of participating in this research with others but it is important for you to know that I **will not** share your personal information with anyone outside of my research supervisors. Research supervisors will be made aware of your pseudonym (a made up name used to replace your real name), not your name. Your information will be kept private in a protected file on my password protected computer or in a locked filing cabinet. Electronic files from this study will be kept for a maximum of seven years for future secondary analysis.

Any information about you will have a pseudonym, not your name. I will not release publicly any personal information that might identify who you are. This includes information such as your birthdate, hometown, or other people and places related to your experience.

If you would like, the information from this research will be shared with you before it is shared with the public. The results will be submitted to a research journal for publication. That is so other interested people can learn from this research.

Who can you contact about this research project?

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me at **506.444.1232** or **acarrier@unb.ca**. You may also contact my research supervisor Dr. Catherine Aquino-Russell at **caquinor@unb.ca**. This proposal has been reviewed by the UNB Faculty of Nursing Ethical Review Committee and the UNB Research Ethics Board (which are committees whose task it is to make sure that research participants are protected from harm) and is on file as (UNB REB # 2017-123).

Do you have any questions?

Part 2: Certificate of Informed Consent

Statement by the participant

I have been invited to take part in research about my experience of learning caring. I have read the information above and the researcher has also reviewed it with me. I have had the opportunity to ask questions about the study and any questions I have asked have been answered to my satisfaction. I consent voluntarily to take part in this study

Print Name of Participant _____

Signature of Participant _____

Date _____

Day/month/year

Statement by the researcher

I have accurately read out and reviewed the information sheet to the potential participant, and, to the best of my ability, made sure that the participant understands the research project as identified above. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and consent has been given freely and voluntarily. A copy of this informed consent has been provided to the participant.

Print Name of Researcher _____

Signature of Researcher _____

Date _____

Day/month/year

Reviewed by the UNB REB: UNB REB # 2017-123
grade 8.9

Flesche-Kincaid Readability:

Appendix H

Thank You Note

Thank you for taking part in my research project. Your input is important to me. It also promotes caring in nursing education. With your input other nursing students' learning experiences can be developed and adapted.

The Canadian Nurses Association (CNA) suggests supporting, using, and engaging in research (CNA, 2008). By taking part in my research project you are practicing in a way that supports the Code of Ethics of Registered Nurses (CNA, 2008). Taking part also supports your growth towards meeting the Entry to Practice Requirements for Registered Nurses (Nurses Association of New Brunswick, 2013).

Congratulations on your active engagement in research. Thank you for your professional development as a nurse!

In Appreciation,

Amy Carrier Fanjoy

Appendix I

Email to Dean or Director of BN Program

Dear (Dean or director),

My name is Amy Carrier Fanjoy. I am a graduate student (Masters of Nursing) and a faculty member with the Fredericton Faculty of Nursing. Today I am writing to you in my role as a graduate student. I am presently engaged in the thesis component of the MN program and have recently completed the proposal discussion and ethics review process (date: _____). My research area of interest is with nursing students learning caring in their nursing education experience. More detail is provided in the abstract below:

Given the importance of caring in nursing, it is necessary to understand the lived experience of learning caring in nursing education. To promote meaningful learning in nursing education, knowledge about nursing students' experiences of learning caring is necessary. Research related to the phenomenon of nursing students learning caring is minimal, therefore a need exists for further description and understanding of learning caring from nursing students' perspectives. This research study is proposed to explore the question, "What is it like for bachelor of nursing students in a four year program to learn caring in a curriculum that has caring as a core value?" The aims of the proposed study are to understand: the meaning of caring for nursing students; the meaning of learning caring for nursing students; factors within nursing education that facilitate and/or limit learning caring for nursing students; and how caring is lived from the nursing students' perspectives within a curriculum that has caring as a core value. van Manen's (1997) qualitative phenomenological research approach will be employed. Selective thematic analysis, as described by van Manen (1997) will be used for data analysis of interview transcripts and curriculum documents. Findings from this study may facilitate learning caring by providing a basis for the development of meaningful instructional methods that can be intentionally integrated throughout nursing curricula.

As described in the abstract above, I am interested in interviewing fourth year nursing students enrolled in the bachelor of nursing program at the University of New Brunswick, Saint John campus. In addition to interviews with fourth year students, I wish to access curriculum documents. The curriculum documents will be explored for the presence or absence of language related to caring as it relates to students' experiences of learning caring. If permission is granted, I wish for this work to start as soon as possible. I plan to recruit students through a number of methods, including visiting them in class, placing posters around the nursing building, posting on the UNB webpage, and if granted permission by student administrator, via social media.

I would be pleased to meet with you to discuss the proposed research in more detail. I am also open to any questions you may have via email. Thank you in advance for considering my request. I look forward to hearing from you.

Sincerely,

Amy Carrier Fanjoy RN BN
Graduate student, Masters of Nursing, UNB, Fredericton

4TH YEAR BN
STUDENTS, YOU ARE
NEEDED FOR A STUDY!

THE RESEARCH QUESTION: WHAT IS
IT LIKE FOR BACHELOR OF NURSING
STUDENTS IN A FOUR YEAR PROGRAM
TO LEARN CARING IN A CURRICULUM
THAT HAS CARING AS A CORE VALUE?

THE OPPORTUNITY: TO TALK ABOUT
AND INFLUENCE NURSING EDUCATION
AND RESEARCH

YOUR COMMITMENT: TWO INTERVIEWS
(APPROXIMATELY 1 HOUR EACH)

**PARTICIPANTS HAVE A
CHANCE TO WIN A \$50
GROCERY STORE GIFT CARD!**

BUSINESS CARDS
HERE

PLEASE CONTACT US!

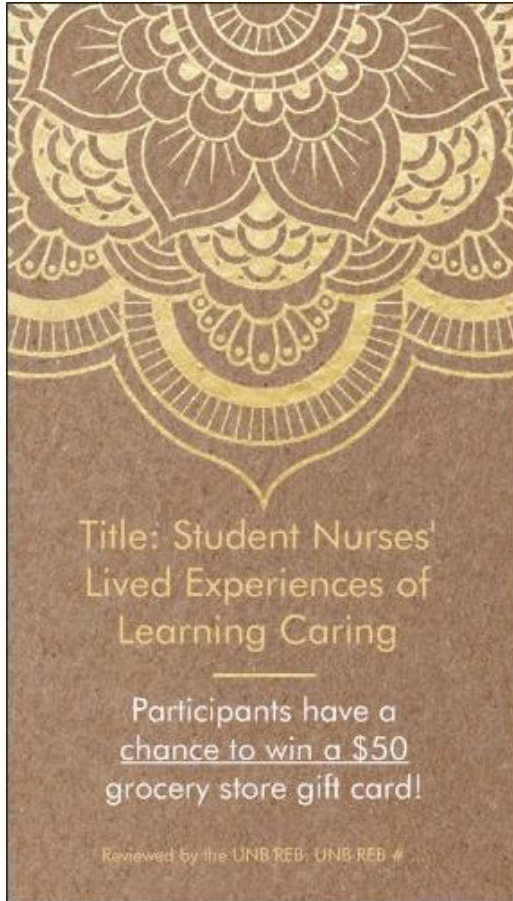
REVIEWED BY THE UNB
REB: UNB REB #...

**MN GRADUATE STUDENT RESEARCHER:
AMY M CARRIER FANJOY RN BN
Email: acarrier@unb.ca
RESEARCH SUPERVISOR:
DR. CATHERINE AQUINO-RUSSELL RN PhD**

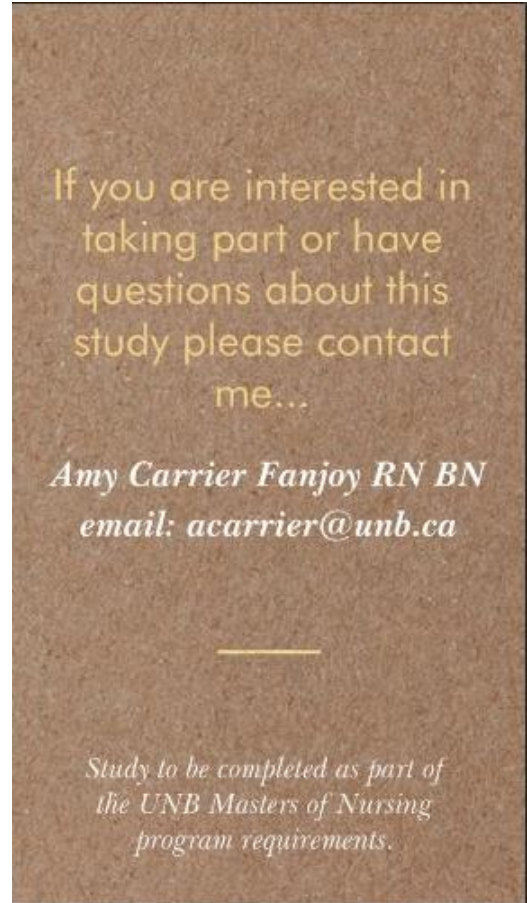
Appendix K

Business Card

Side 1:



Side 2:



CURRICULUM VITAE

Candidate's full name:

- Amy Melissa Carrier Fanjoy

Universities attended:

- University of New Brunswick, 2002-2006, Bachelor of Nursing
- University of New Brunswick, 2010-2018, Master of Nursing

Publications:

- Carrier Fanjoy, A. M. (in press). Case study: Nourishing the Mind and Soul. In Potter, P., Perry, A., Stockert, P., Hall, A., Astle, B., and Duggleby, W., *Fundamentals of Nursing* (6th ed.) Canada: Elsevier. *Fall, 2016*

Conference presentations:

- Exploring a Pattern in Practice: Caring Presence, co-created with Dianne McCormack RN, PhD
 - Presented at the Faculty of Nursing Research Day, *April 26, 2013*