

Citation for published version:

Kate Young, Rosemary Godbold, and Pat Wood, 'How do student nurses learn to care? An analysis of pre-registration adult nursing practice assessment documents', *Nurse Education in Practice*, Vol. 28: 168-174, January 2018.

DOI:

<https://doi.org/10.1016/j.nepr.2017.10.004>

Document Version:

This is the Accepted Manuscript version.

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How do student nurses learn to care?

An analysis of pre-registration adult nursing Practice Assessment Documents

ABSTRACT:

There is international concern about the quality of nursing in resource constrained, high technology health care settings. This paper reports findings from a research study which explored the experiences and views of those involved in the education and learning of 'caring' with adult pre-registration students. A novel dataset of 39 practice assessment documents (PADs) were randomly sampled and analysed across both bachelors and masters programmes from September 2014 – July 2015. Using an appreciative enquiry approach, the Caring Behaviours Inventory aided analysis of qualitative text from both mentors and students within the PADs to identify how student nurses learn to care and to establish whether there were any differences between Masters and Bachelors students. In contrast with existing research, we found a holistic, melded approach to caring. This combined softer skills with highly technologized care, and flexible, tailored approaches to optimise individualised care delivery. Both of these were highly valued by both students and mentors. Pre-registration MSc students tended to have higher perceptual skills and be more analytical than their BSc counterparts. We found no evidence to suggest that caring behaviour or attitudes diminish over the course of either programme.

Keywords: Learning to care; Nurse education; Appreciative inquiry; Caring; Behaviours inventory

Highlights

- Students and mentors emphasise flexible, holistic care, combining technical *and* soft skills to optimise individual care.
- Our findings suggest that MSc students have higher perceptual acuity and analytical skills in practice than BSc students.
- There was no suggestion that caring behaviours or attitudes diminish across the course of pre-registration programmes.

INTRODUCTION

Care and compassion have been explicitly recognised in England's pre-registration nursing's essential skills cluster (Nursing and Midwifery Council, 2010), the Chief Nursing Officers Vision for nursing (Chief Nursing Officer, 2016) and the new framework for nursing (NHS England, 2016). Yet a systematic review shows a research evidence gap about holistic competence in pre-registration training (Yanhua and Watson, 2011). Maas Burhans and Alligood (2010) showed students place most value on situated learning in practice. This paper reports qualitative accounts of practice experience from adult pre-registration students and their mentors. This study emerged from anecdotal evidence about clinical practice from students, mentors and link lecturers; significant research and public enquiries into health care which

indicate inadequate nursing care; and lack of evidence about how nurse educators should move forward. The authors also planned comparative data analysis between pre-registration Masters and Bachelors students.

The first component of the research focussed on analysing the qualitative text written by both Masters and Bachelors students and their mentors in their Practice Assessment Documents (PADs). The second involved focus groups with students, mentors and link lecturers, the findings of which will be reported elsewhere. This paper comes from Phase 1 of the larger study which explores caring behaviours noted by BSc and MSc pre-registration nursing students in practice. The preliminary report for the MSc is deposited in our university research repository (Young, Godbold & Wood, 2015). We intend to publish findings from Phases 2 and 3 sequentially in separate papers. The underpinning approach taken across all data collection points was appreciative inquiry which seeks to explore positive features of a culture in order to make improvements within an organisation (Bushe, 2011).

BACKGROUND AND LITERATURE REVIEW

As a basis for the research, we conducted a systematic search of the international literature using Cinahl and Pubmed in March 2013, which was updated annually in August 2014, 2015 & 2016. All English language papers were included with no date restriction. This was a rapid review, which is a method increasingly used for the purposes of research, to reflect a literature base which was growing exponentially during the lifetime of the project, and the time and resource restrictions (O'Leary et al, 2017). Supplementary lateral and hand searching techniques have also been employed throughout each phase of the study. Themes from this literature will now be discussed.

The burgeoning literature about caring in nursing practice reflects the concerns of a profession attempting to reconcile the ever increasing and well documented threats to caring internationally, and the appropriate response from nurse leaders to what is described globally as a 'crisis of care' (Darbyshire & McKenna, 2013; Kagan, 2014). While for many this crisis culminated in the UK with the publication of the Francis Report, concerns about caring have been documented in nursing scholarship for decades (Bassett, 2001). For example, UK researchers have highlighted relationships between staff and patient well-being, high staff stress and lower levels of empathy for patients, and quality care and staff burnout (Maben, 2008; Bridges et al, 2013). Shorter patient stays, more technologized care, and fractured care delivery also impact on the quality of patients experience (Goodrich, 2011; Goodrich and Cornwell, 2008; Feo and Kitson, 2016).

The impetus for this study came from our work as link lecturers with students on clinical placements which reflects empirical evidence: that students can be overly focussed on technical / rational aspects of nursing and reliant on protocols for guiding care delivery while being assessed against frameworks emphasising accomplishment of technical skills. This focus has been linked to the professionalization of nursing, with nurses associating this aspect of their role with higher status, significance and value (Flatley and Bridges, 2008; Stevens & Crouch, 1995). The move to a graduate nursing workforce has also been implicated, with some arguing that nurses move away from direct patient care as they become more highly educated (Richardson et al, 2015; Francis, 2013). However, this argument is at odds with evidence that suggests that patient outcomes improve with a graduate nursing workforce (Aiken et al, 2013). Another perspective suggests that work intensification (higher levels of acuity and technology, and rapid patient throughput) can lead to emotional exhaustion and

disengagement (Kubicek et al, 2012). In challenging clinical environments nurses may adopt task oriented approaches and focus on technological aspects as a self-protection mechanism (Curtis, 2013; Bridges et al, 2013).

There are well established links between caring, patient centred care and positive patient outcomes (Ferguson et al 2013; Fingfeld-Connett, 2008) which is promoted as a counter to poor quality care (see, for example, the report of the Willis Commission, 2012). However, patient centred care is less likely to be sustained in environments with resource shortages and low nurse patient ratios where comforting and talking to patients, developing care plans, and educating patients and their families are activities most likely to be left undone (Aiken et al, 2013; Ausserhofer et al, 2013). The literature also associates reduced resourcing with greater emphasis on medical diseases, symptom management, diagnoses and cost-effective treatment protocols (Fingfeld-Connett, 2007). Working in poorly resourced environments has undesirable knock on effects. For example, workplace stress and burn out may lead to bullying, and nurses who experience abuse are less likely to provide high quality care (Rowe and Sherlock, 2005).

While environments in which nurses work are an internationally established predictor for job satisfaction and intention to leave (Choi et al, 2013) they also impact on the socialisation and education of nursing students; factors which are highly influential on caring behaviours. For example, compassionate care can be compromised by dissonance between professional ideals and the reality of practice, with much of students' socialisation into compassionate practice taking place in environments challenging to high quality care (Curtis et al, 2012). This can result in students managing feelings of vulnerability and uncertainty by balancing engagement in compassionate practice with their own emotional well-being (Curtis, 2013),

with some indication that student nurses' levels of empathy may decline during their training programme, particularly in their first year, with the highest decline in those with the most clinical experience (Ward et al, 2012).

Taken together, this research challenges 'values based' recruitment practices (DH, 2012). The assumption that nursing students with caring attitudes can reflect these as caring behaviours with patients across their working life is unproven (Stenhouse et al., 2016). Education and socialisation processes are thought to raise significant challenges for nurse educators (MacKintosh, 2006). Given the obvious associations with poor resourcing, their response is remarkably apolitical. The literature is focussed on finding effective evidence and theoretically based educational solutions. While finding an agreed definition of caring remains elusive (Corbin, 2008), the scholarship tackles the difficult, but vital question of whether caring can actually be taught or whether it is innate (see for example Cornwell, Smith & Donaldson's 2013 editorial discussion). There is broad acceptance that whilst caring *is* innate, it can be taught and cultivated (Richardson et al, 2015; Dewar & Mackay, 2010; Bassett, 2001). To this end, much work has been done on equipping students with tools such as emotional intelligence, resilience, empowerment, confidence, high self-esteem and motivation for learning to help them remain positive and caring in challenging environments (Warelow & Edward, 2007; Bradbury-Jones et al, 2007). While educational activities can enhance compassionate and empathic behaviours (Richardson et al, 2015; Williams & Stickley, 2010), the role of mentors in practice are crucial (Bradbury Jones et al, 2007). Thus, supported transition from student to qualified nurse is important (Saber et al, 2015).

Educating nurses can also raise the quality of care - for example, Kada et al (2009) found specialist knowledge fostered positive attitudes towards patients with dementia. This can

lead to higher levels of engagement and less burnout (Kubicek et al, 2012), but concerns remain about educational delivery, particularly in undergraduate settings. Nurse teachers cite under-resourcing, growing student numbers, and considerable changes to the nurse education landscape as sub-optimal for learning compassionate care, limiting meaningful discussions and small group work (Curtis, 2013).

To summarise, the literature reveals care and compassion to be multi-faceted concepts which are much studied and debated. The factors which are said to influence caring in nursing are often contested, but include: student nurse and staff recruitment, retention and wellbeing; work environment stressors (e.g. work intensification, technological change, resources, organisational and management strategies); educational preparation or continuing education provision (both theory and practice); and lastly, the challenges associated with consistently translating ideals into practice in real world settings. This formed the background to the study of practice learning in student nurses and our focus on their accounts of caring activity.

METHODS

Our aim was to elucidate experiences and practices centred on the act of caring, or learning to care, in nursing practice. The student's PADs are structured around Essential Skills Clusters (ESC) based on the standards for pre-registration nursing issued by the UK Nursing and Midwifery Council (NMC, 2010). They are completed on every placement by student nurses and their mentors and used to demonstrate that competence has been achieved. The PADs we accessed required the student and their mentor to complete written evidence to support each element of care of the ESC, and supplementary text in preliminary, intermediate, and final interview records. Formal research ethics review was deemed unnecessary by our institution as we were examining routinely collected data retrospectively to which we already

had access, and anonymised datasets were large. Holland (2011) explores this issue of routinely gathered data and ethical approval. Within our institution, such work is also governed by University protocols for ethical service improvement design, which allows for publication.

As all of our pre-registration students were completing handwritten Practice Assessment Documentation in the form we scrutinised (we have at least 900 students per year, some submitting more than one PAD in the time period), those excerpts (each chosen from 100 + page document, themselves randomly chosen through anonymous inclusion) are not identifiable other than to the author. At the outset, mentors from practice areas were aware of our study, and student groups were informed through posters and were able to request that their documentation was not included, but none did so. We were part funded through internal quality uplift monies as well as research funding. The service improvement element has been taken forward with students, lecturers, practitioners and managers who attended a workshop day and have been working with us to improve current provision. This is currently work in progress.

Documents can be considered to 'form a 'field' for research in their own right' (Prior, 2003). Documents are produced in a particular health care setting and they have a function, in this case the assessment of the student, but also serve to describe particular events or phenomena, in this case, 'caring behaviours' (Bowling, 2014). The underpinning ideology of the broader research study was Appreciative Inquiry: looking for positive features of a culture, in this case: caring behaviours, in order to make improvements within an organisation (Cooperrider & Whitney, 2005). We hope that by identifying and sharing good practice we

can inform debate and improve nurse education centred on how students learn to care in clinical settings.

To analyse the considerable volume of qualitative data present in the student's PADs (extracted from approximately 1950 A4 pages), a structured framework focussed on caring behaviours was required. The Caring Behaviours Inventory (CBI) (Wolf et al, 1994) was identified from the literature and chosen because it had been subjected to reliability and validity testing using experts and clinical nurses (Wolf, 1986) and subsequently correlated with patient satisfaction (Wolf et al, 1998). The Caring Behaviours' Inventory has the following categories: Assurance of human presence, Professional knowledge and skill, Respectful deference to another, Positive connectedness, and Attentiveness to the other's experience. Further detail of what constitutes behaviours within each category is provided by the authors of the CBI (Wolf et al 1994) and these were used to facilitate in depth analysis and categorise the data.

To pilot our approach, each of three post-doctoral researchers randomly selected two PADs and used the CBI to assess its suitability for analysing the textual data. We coded each PAD manually using the CBI's item clusters (Wolf et al 1994) for each category of the CBI. We then put the coded data under each CBI category. Each section of coded data was examined to elicit what students and their mentors believed to be caring behaviours. We reviewed the coding to check for conceptual clarity and transparency. The pilot PADs were exchanged and blind coded between the three researchers and established a high degree of dependability and consistency. Our part and effect on the analysis coding process was reflexively discussed. Credibility was addressed by checking descriptions, engaging with the documents, having team meetings and maintaining a clear audit trail (Lincoln, 1995). Team meetings also ensured

confirmability throughout the length of the study, establishing that our interpretations of the findings were derived from the data (Tobin & Begley, 2004). During the pilot study, an additional category was added: 'Learning foundations of care'. This was deemed necessary because the original CBI had been designed to capture the caring behaviours of qualified nurses, not students, and did not capture the experiences of learning evident in the data.

Following this, we randomly sampled the PAD documents: BSc (n=22) and MSc (n=17) according to year groups. By doing this, we could map the way that caring behaviours were described in practice across the length of the programmes. Wherever possible, we allocated team members to PADs based on their lack of knowledge of student groups. The CBI, with our additional category "learning foundations of care", was used to carry out a framework analysis of the free text sections of each PAD document using the following key stages: Familiarisation, Identifying a thematic framework, Indexing, Charting, Mapping and interpretation (Richie & Spencer, 1994, Lacey & Luff, 2007). We had previous knowledge of the PAD, and familiarised ourselves with each document by reading and re-reading. All of the free text in each PAD was coded using the CBI framework by applying colour coding data sections corresponding to each of the categories, with another where learning was elemental and specifically identified. Each section of colour-coded data was examined to determine what students and their mentors believed to be caring behaviours. Each researcher took two categories of the CBI to analyse the data and review overall coding. This data was then displayed to create a chart of the data which could be read across the whole dataset. We reviewed the data sets together, discussed where coding overlapped, and/or new themes or sub-themes were emerging. Following the Framework Analysis method described above, we

mapped our data and interpreted their meaning so, as a result, some of our themes transcend the original CBI categories.

Our findings will now be presented in this paper under the following headings: Adaptive, Flexible Care; Seeing and Doing in Practice; Being Watchful; Avoidance of Harm; and Management of Learning.

FINDINGS

Adaptive, Flexible Care.

The emphasis on adaptive, flexible care was the most common overarching theme identified during mapping and arising across categories. The ability to assess and respond to patient situations was viewed as essential to students:

'I have been feeding many patients. When I do I ensure that they are in a good position and are fed straight on. I always ensure that patients can reach their drink and that it is in the appropriate container for the patient's needs' (KRY1)

Patient choice adds complexity and underpinning knowledge helped students' adaptability:

'I get involved and help aid patient experiences and outcomes. For example, revisiting a patient who has a wound follow up appointment, checking the wound is healing..., keeping the patient informed and offering them options' (RG7)

Flexible care included many dimensions within student's writing. It was individualised to nursing environment, family context, holistic and culturally sensitive.

'I ask the patient or their relative questions about their needs to determine their level of independence, their psychological state, any social needs at home and any cultural or religious requirements...[these] are documented...so that these can be handed over.' (KRY2)

Students gave examples of caring behaviours which required role expansion and contraction to tailor patient care.

'one Italian patient does not speak any English so I used my mobile phone to try to find key phrases to try and communicate with him and keep him entertained' (KRY2)

Students also linked compassion, empathy and communication to the provision of individualised care. They commonly wrote about communication by focussing on care of

vulnerable patients, rather than with those who appear to cope well. Students describe making extra effort and going 'out of their way':

'I will talk to the patient and try and take their mind off what I am doing if I feel that they are anxious or in pain. In hospital when patients seem bored or depressed, I will spend some time talking to them or fetch them magazines or leaflets to read. One patient with learning disabilities expressed that she was fed up so I went and got her some colouring books and spent some time helping her complete her jigsaw puzzle.' (KRY2)

However, the mentors commented more generally about students emphasising consistency when demonstrating reassurance, empathy and compassion:

'The patients felt reassured by her presence.' (PW4)

'[Student] has demonstrated a high level of compassionate care. Has excelled on... a challenging ward. She has worked with many patients with dementia and displayed empathy and compassion' (RG2)

'I saw that she acts in a warm and sensitive way towards her patients. She is kind and caring ... she has dealt with patients concerns in an understanding way' (PW2, mentor)

Students and mentors wrote about developing therapeutic relationships to deliver compassionate care and enhance communication, including communicating with other health professionals to enhance care.

'I have cared for patients whose families have not been ready for their relative to pass away and have insisted treatment to continue though it was distressing to the patient. This was a particularly difficult situation and when the patient passed away the family were ever so distraught. I ... found this quite an upsetting experience...I feel good communication has made passing of a loved one easier to accept and makes a 'good death'. I am happy to communicate with other health care professionals to support me in the care I have given' (KRY1)

When the student's linked communication with building therapeutic relationships they tended to write in general terms about how they behaved:

'I understand how talking to patients helps build a relationship and I always ensured that I gained informed consent from the patient before doing anything – this helps to build relationships' (KRY4)

Seeing and doing in practice.

The most prominent CBI category evident across the PADs was professional skills and knowledge. For example, the students and their mentors commonly used the PADs to showcase the knowledge and skills acquired on students' placements, applying this to care delivery:

'... was involved with medication rounds and preparing injections under supervision and she is capable to manage the workloads. Also attended IV infusion pump training and gained more knowledge of using pump.' (KRY1)

We also found evidence that learning to care by acquiring knowledge and skill was linked to student's observing and learning in practice what they had been taught in class. Students talked about applying existing knowledge to practice, but also about getting better understanding of theoretical knowledge through seeing it in clinical environments. Some took this further, demonstrating how their applied knowledge facilitated provision of adaptive flexible care to meet patient's individual needs;

'I have developed knowledge about how illness and disability can affect individuals and their families at different stages. An example of this was an elderly lady admitted with a UTI and confusion, her family were distraught with this and therefore a sensitive approach was needed when... dealing with this family, taking respect for personal preference food choices, as she was Jewish she required kosher meals' (RG11)

Sometimes this developing knowledge was explicitly and directly linked to the student's ability to care and they gave examples of how they extended their new found knowledge and technical skills to enhance care delivery;

'On this placement I have gained a better understanding of the types of dressing available and how these can help the wound healing.' (RG 13)

Being Watchful.

This theme arose frequently in our PAD data, with clear links to observation, monitoring the patient and facilitating self-care. Students and mentors gave plentiful examples of how students assess their patients and identify when to take appropriate action or seek advice.

'Areas of strength includes ability to manage own caseloads and identify deteriorating patients and act appropriately' (KRY 6)

Most commonly, students reflected on their own care, but students also checked the quality of care delivered by others:

'Recently I had to constantly remind another staff member to cover the patient whilst we washed him. I asked the staff member to put himself in the patient's shoes. By acting in this way I am able to maintain the patient's dignity' (PW2)

Mentors and students wrote of nursing watchfulness as continuous vigilance. When done well, this was seen as more complicated than taking action:

'She is able to communicate at all levels and makes sure that the patients feel very relaxed and calm during procedures.' (PW5, mentor)

Harm avoidance

This appeared frequently in relation to a wide ranging set of nursing activities. Students wrote about planning nursing care to prevent acute and long-term deterioration in mental (e.g. informed consent, patient autonomy), physical (e.g. mobility, infection control, nutrition and alleviation of symptoms) and emotional health (e.g. safeguarding from abuse). Stronger students connected these aspects of health in a holistic way. Individualised harm avoidance activity was often seen as empowerment (see first example) and sometimes linked by students to compassionate practice (see second example):

'A patient with a brain lesion went to the bathroom, however he was unsteady on his feet and required help back. Me and a staff nurse provided such support, offering encouragement and advice as he shuffled back to bed. This action helped him to retain some of his independence.' (KRY14)

'I have supported / safeguarded patient from vulnerable situations and protected them from harm e.g. using communication skills/ care/ compassion to reassure patients with dementia and stop them pulling out catheters/ cannulas vital to their wellbeing. I have used the same skills to ensure the similar patients took their medication, took on adequate fluids etc.' (RG13)

Maintenance of people's infection control and safety was commonly written about as organisation of environment, and not linked to compassionate practice. However, links were made between harm avoidance, understanding and flexibility:

'The disposal of clinical waste in the community is sometimes difficult due to clients not having clinical waste bins. Where possible clinical waste is disposed of in a clinical waste bin however in clients own home waste is double bagged and given to the clients/ carer to dispose of into outside wheelie bins. All clients requiring sharps at home are supplied with a sharps disposal box, where handwashing facilities are not accessible I have used alcohol hand rub' (KRY1)

Management of Learning.

Students were able to discuss how their learning influenced patient care:

'I actively try to seek knowledge and extend my skills by using various sources of information, ward intranet site, policies and procedures of ward and hospital...This helped me to provide good quality care to the patients I cared for who suffered from C Diff' (PW5)

The link between competency, confidence and patient care was clearly identified by mentors:

'She needs to work more on her clinical skills, gaining more confidence and independence' (KRY1)

'[Name] always show a confident approach when dealing with patients' needs and they in return show confidence in her care' (KRY3)

This confidence has to have appropriate limits:

'[Name] has gained confidence and has worked within her capabilities' (KRY1, mentor)

When writing about their learning, students focused on demonstrating competency. It was particularly common to find students listing clinical skills they had developed:

'Due to the many opportunities given to me by the staff I have learnt many new skills such as wound care, bandaging, dressing information and aseptic technique.' (KRY5)

Mentors also reflected this approach to learning in their comments:

'needs to continue to develop practical skills in wound care/ aseptic technique, has improved in patient medication administration and patient admission and care planning' (KRY3, mentor)

Stronger students took a more active role in shaping their learning:

'I seek to extend my knowledge by researching areas I feel I am lacking in and taking additional learning opportunities such as spending days with a practice nurse at the leg ulcer clinic' (PW3)

BSc and MSc students recorded their learning about caring in the PADs with varying purposes. This freely written text often changed within each PAD, reflecting personal learning style and chosen clinical focus. Clinical experiences with particular significance for patients which required student growth were commonly recorded (exemplars shown in previous categories).

Note-taking on where to find relevant information about clinical skills was evident:

'I sought to understand and extend my knowledge and skills by reading in depth, asking questions, asking to be shown how to do tasks, going on doctors rounds and working closely with other staff members.' (RG12)

MSc students on the accelerated course were more commonly seen as hard working and demonstrated better ability to engage others in their learning:

'Has worked hard with all her interest, involved in all activities with patients, patient's families and all team members' (KRY1, mentor)

This was frequently linked by mentors to excellent care delivery and while students managed their own learning, there was a clearer picture of shared responsibility in achieving competence in clinical settings:

'I seek information regarding patient care for myself and colleagues by reading hospital policies, guidelines, the internet and asking other professional healthcare staff'. (PW2).

'Shares her research and discusses about better ways of providing care for better patients experiences' (PW2 mentor).

DISCUSSION

The current research base and polemic tackling the purported 'crisis in care' in nursing appears to have taken an either / or approach to the delivery of technologically skilled care and fundamental care. Examples of research which requires participants to choose between technologized care and softer non-life saving skills, prioritise tasks and reduces care delivery to component parts, risks painting a fractured picture of how nurses actually deliver care (see for example Ausserhofer et al., 2013; Watson et al, 2001 and Khademian & Vizesfar, 2008).

Likewise, the required format for student assessment through PADs, divided up according to the essential skills clusters, requires students to consider their care in a reductionist way. Despite this division, we found students often gave more positive, melded examples when given opportunity within their PAD to use free text, describing technical, skilled care delivery combined closely with fundamental care. In particular, it was evident that some students addressed multiple elements of the CBI, giving 'woven' accounts of their care. This was characterised by a switching from one theme to another in the same section of data according to the framework of caring behaviours (shown in one exemplar quote with CBI categories assigned in brackets):

'I can appreciate the benefits [management of learning] of educating individuals and the wider public [Respectful deference] to promote and maintain the health [investment in another's needs] and population. An example of this is hand washing initiatives [good physical care] from the department of health. We can as nurses lead by positive example [knowledge and skill] to actively encourage patients and relative to partake in their own care [positive connectedness] with regards to this.' MSc RG11

While this raised considerable challenges for coding the data, it is an important finding. Previous scholarship indicates a research evidence gap about holistic competence in pre-registration training (Yanhua and Watson, 2011), but we found multiple positive examples where students' learning and behaviours demonstrated holistic approaches to care. In particular, there was a large emphasis on the flexibility required when caring for patients which ran through all CBI categories. Adapting care to patients and to context was emphasised spontaneously by student nurses documenting their own experience of everyday, dynamic practice. Importantly, we found evidence that this nursing activity is also highly valued by their mentors in their written comments about students. It seems possible that both groups wish to demonstrate their caring attitudes to patients by purposefully writing about flexible, tailored care delivery. While the distinction has been made between

caring attitudes and behaviours (Morse et al, 2006), our data suggests a cohesive approach whereby students and nurses promote good caring behaviours through being responsive to the situations encountered. These findings are significant in organisational contexts which are thought to be foundering in their provision of personalised care and holism (Feo and Kitson, 2016).

The CBI includes skills and knowledge as a component of caring and our data demonstrates the students' emphasis on this aspect of the nurse's role. This may be related to the competency based assessment within the PADs, which preceded the free text. However, our data suggests that despite research which finds that nurses prioritise technical care over softer skills, students perceived flexible application of their knowledge and skills as an essential part of their nursing care. They saw separation of technical skills and caring as artificial, instead their delivery of patient centred care was dependant on technical skills/ability. This is positive and encouraging, particularly given that documents were written purely for student assessment, and only retrospectively used for research. This emphasis on holism was also found in PAD reports from mentors about their students in practice settings.

Support by mentors in placements has been shown to increase student retention and enthusiasm for the profession (Pearcey and Elliot, 2004) and new nurses say this occurs when practitioners exhibit a sound knowledge base, holistic caring and work within safe practice environments (Ferguson, 2011). Our findings also show that students and mentors highly value these attributes, particularly when related to patient care. Students learn from lecturers who model and teach intrinsic qualities of caring and empathy, emphasising nursing aesthetics, not simply technical skill acquisition (Maas Burhans and Alligood, 2010). Our findings demonstrate that this is also true in practice learning more generally. While

compassion, empathy, communication and therapeutic relationships were recognised as important within PADs, they were most often articulated by the students in relation to highly vulnerable patients.

Achieving consistency in placement quality is problematic (Skaalvik, Norman and Henriksen, 2012), and evidence from Francis and Keogh Reports (2013) acknowledge this while recognising the symbiotic relationship between organisational context, quality of patient care, and nursing education. This link to nurse education (based on 50% theory, 50% practice) has been noted by nurse academics (Council of Deans of Health, 2013; Darbyshire & McKenna, 2013) and is particularly acute within high intensity, accelerated pre-registration Masters programmes in which students are expected to complete compulsory practice hours and meet professional and academic standards within two years. We found that while the descriptions of learning about nursing care in PADs were varied in length, detail, perceptual acuity and analytic skills, MSc students tended to write longer more detailed accounts of their care, demonstrating higher perceptual acuity and analytic skills than BSc students. This was mirrored by the mentors, who appeared to be more rigorous in their approach to documentation for these students, with similar emphasis on holism. Concerns have been raised about consistency of caring behaviours across the course of pre-registration nursing programmes (Ward et al, 2012). However, we found no indication that the nature or emphasis on caring changed over the course of either BSc or MSc pre-registration adult nursing programmes. This is in keeping with Khademian & Vizeshefar (2008), counteracting arguments that caring reduces over the lifetime of nurse education.

LIMITATIONS TO THE STUDY

The material presented in this paper is one part of a relatively small study in a British University. The documents used were not written for the purposes of research, but retrospectively obtained during 2014. Students and mentors knew that module leaders would be auditing them, so it is possible that what was written was motivated by a desire to present themselves in the best light possible.

PAD were lengthy, and selection of narrative material for analysis using framework analysis was essential. The material coded in the PADs reflected a large emphasis contained within much of the writing by students and mentors more generally. However, it is possible that a different method of data analysis may, in itself, have led to different emphases within the data selected. There was also evidence from our data which suggests that whilst the CBI was useful to ensure consistency in approach in the earlier part of the project, we believe that there is a need to update several of the phrases within each element of the framework to reflect contemporary understandings and accepted practice.

The researchers followed ethical protocols and are experienced qualitative researchers, meeting regularly to ensure dependability, consistency and trustworthiness in the data collection and analysis. However, as with all qualitative research, it is possible that others would have selected and interpreted the data differently.

Lastly, there is a concern that nurse mentors who work with students in busy practice environments have difficulty meeting the complex demands of their role (Duffy, 2004; Robinson et al, 2012). Sometimes the completion of PAD may be done in their own time; indeed, some evidence suggests that documentation may be rushed, or (in cases where there is 'failure to fail') 'fudged' (Robinson et al, 2012). We acknowledge that our data is only as good as the documents reviewed. However, the fact that all PADs emphasised these

themes, rather than omitted them, is a significant finding important to nursing practice. In busy circumstances, students and mentors are prioritising their records about this aspect of care.

CONCLUSION

Qualitative analysis of free text from student's Practice Assessment Documents suggests that caring behaviours in practice are highly valued by students and their mentors, particularly when they emphasise adaptation to patient and context, holistic application of knowledge and skill, harm avoidance, watchfulness and present further opportunities for learning. These accounts of care were lengthy, and contained complex material, much of which were classified as 'caring' using the CBI. Our findings from this novel data source are significant because they demonstrate a more holistic, melded approach to caring. These records of practice learning show students and mentors valued combining softer skills *with* highly technologized care *and* flexible, tailored approaches which aim to provide optimal, personalised care. This adds to the current research base. We also found that pre-registration MSc students are more likely to be analytical and have higher perceptual skills than their BSc counterparts, with no evidence that caring diminished over the course of either programme. Other research is required to inform these findings, but nurse educators may be encouraged with evidence that students are adopting and valuing holistic, tailored, personalised approaches to caring. Further phases to this research study are ongoing.

Conflicts of interest: none.

FUNDING SOURCE:

Health Education North Central and East London (Health Education England)

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