Nursing students' evolving professional values: capturing their journey through co-operative inquiry

Abstract

Aim/objective and Background: Despite a worldwide emphasis in nursing codes of practice that state nurses must uphold professional values to be caring and compassionate, evidence continues to emerge of poor-quality care standards. Existing literature attests to a tendency to deteriorating caring values as students' progress through their nursing programme. In response, one university in England exposed pre-registration nursing students to a values-based curriculum which embedded Todres et al's. (2009) Humanising Values Framework.

Design and Methods: This paper describes the later stages of a co-operative inquiry, where students as participants explore their evolving values around person-centred approaches to care as they engaged with clinical practice. Data were collected between 2013 and 2016.

Results and Conclusion: Findings reveal how students developed their confidence and resilience in the face of situations that challenged their value base by internalising a humanised approach to care. They demonstrated this in practice by using problem-based coping strategies, peer and mentor support. Engagement with a curriculum based on humanistic philosophy encouraged students as participants to feel confident in the practice of person-centred care.

Key words: Values, Humanising Care, person-centred care, Cooperative Inquiry, nursing students.

Highlights

- On entry to a pre-registration nursing programme students draw on their personal lifeworld to express their values about nursing;

- Exposure to a curriculum based on the Humanising Values Framework enabled students to build, enhance, own and thereby practise person-centred care as an integral facet of their own practice;

- Engaging in co-operative inquiry and co-creation enabled students to build resilience and feel empowered;

- Students reported adherence to person-centred care professional values throughout their programme.

Introduction

Prioritising the person receiving care is a key tenet of nursing professional values (International Council of Nurses (ICN) 2012; Nursing and Midwifery Council (NMC), 2018a/b). Prioritising people is also part of a global strategy to develop people centred health care through empowering and engaging individuals, families, and communities towards safe and effective care (World Health Organisation 2016). However, according to Maxwell (2017) prioritising the human connection is necessary but not sufficient to provide safe and competent person-centred nursing care; nurse education curricula should bring together values supporting humanised and person-centred care together with the knowledge and skills required to ensure safe and effective practice. Whilst nursing knowledge and skills content might be assumed within nursing curricula internationally, implementing them in clinical practice in a person-centred way is dependent on personal values and professional cultural norms. Evidence suggests that caring values, central to person-centred approaches, are expressed by first year nursing students but diminish over their nursing programme; consequently, at the point of qualification as registered nurses, they demonstrate

instrumental caring but the presence of expressive caring is reduced (Murphy et al., 2009; Loke et al., 2015).

Cognisant of these debates, a pre-registration nursing curriculum at Bournemouth University was designed based around the concept of humanising care values (Todres et al., 2007). A multi-stage, longitudinal co-operative inquiry of how students' values evolved over time was instigated alongside curriculum implementation. Stage one explored the subjective values of new nursing students on their first day on the programme; this is described in detail in Scammell et al., (2017); in summary we found that regardless of previous caring experience, students expressed meaningful and authentic descriptions of humanised care values, thus challenging recruitment policies that recommended candidates need previous care experience. Our purpose in this paper is to describe the subsequent phases of the study, examining how the same cohort of nursing students described and experienced their values as they progressed through a three-year values-based curriculum which embedded Todres et al's., (2009) Humanising Values Framework.

Background

The development and presence of professional value-based curricula for undergraduate pre-registration nursing programmes has been emphasised in world-wide codes of practice (ICN, 2012; NMC, 2018a). In the United Kingdom (UK) statements have been made by government organisations stating that nursing is person-centred with nurses being compassionate, caring, courageous and competent (DOH and NHS Commissioning Board, 2012; Scottish Government, 2017). This being in response to serious failings reported by the Public Inquiry into Mid-Staffordshire NHS Foundation Trust (Francis, 2013), who found that nurses and other health care workers engaged in dehumanised practices which resulted in increased patient morbidity and mortality. The investigation highlighted that a financially-oriented management culture contributed to dehumanised care, negatively impacting on those receiving care and workers. It was suggested that nurses' failure to uphold person-

centred, professional values led to poor quality care. Due to contextual psychological factors, perceived loss of values was complex but relate to "inattentional" blindness, cognitive dissonance and situational institutionalisation and compassion fatigue (Bentzen et al., 2013; Paley, 2014; Paley 2015; de Vries and Timmins, 2016).

Indeed deficiencies and gaps in care quality is a global issue: for example, in nursing homes in the Republic of Ireland (Department of Health and Children, 2009); Social Care (Health Service Executive, 2016); in the USA (Fennell et al., 2010) and in care facilities in Jordan (Mudallal et al., 2017). According to Aiken et al. (2011), in their study of hospital work environments across nine countries, found several factors leading to a reduction in the quality of care in health care settings. They include a lack of human and material resources and a management culture that fails to support bedside nurses, which negatively impacts on quality patient care and leads to high levels of nurse burnout or compassion fatigue.

Professional socialisation studies of nursing students highlight that in the clinical placement element of their programme, a climate of staff shortages, limited resources, management targets, increasing levels of technology and complex patterns of care, are resulting in students being increasingly exposed to care environments that repeatedly challenge their values (Thomas et al., 2012; de Swardt et al., 2014; Thomas et al., 2015). Melia (1987) offered evidence of negative student experiences and stress associated with practice. Others show limited abatement of negative experiences and evidence of bullying and harassment (Johnson, 2009; Dellasega, 2009; de Swardt et al., 2014). Murphy et al., (2009) identified that first year nursing students demonstrated expressive and instrumental forms of caring however, by their third-year students scored significantly lower in expressive caring but maintained their scores for instrumental caring. They argued that this was due to the tempering of idealism that came with being exposed to the realities of practice. Using the same questionnaire Loke et al., (2015) found similar findings. The authors argued that in a climate of high technology and cost constraint, it is important that nurses do not increase

aspects of instrumental caring by reducing opportunities for expressive caring that focus on the person and person centred practice.

UK nursing students spend 50% of their programme in academic study and this challenges nurse lecturers ability to influence the unpredictability of a dynamic practice culture and support students. Rosser et al., (2019) argue that this pedagogical challenge can be met by adopting a curricular philosophy for education and nursing practice based on valuing what it is to be human. Practicing humanised care is recognising that we are all human, living and experiencing the intersubjective, embodied and temporal nature of lived experience (Dahlberg et al., 2009; Galvin, 2010; Galvin and Todres, 2013). The lifeworld approach builds on Husserl's (1936/1970) notion of lifeworld, Heidegger's (1927/1962) interpretation of human freedom and authenticity of self and Merleau-Ponty's (1964) notion of interconnectedness. According to Galvin and Todres (2013), the concept of lifeworld-led care relates to the individual and shared experiences of living, the personal and intersubjective nature of what it is to be human. They argue that lifeworld-led care is both person centred practice and an existential view of being human. They present the Humanising Values Framework (HVF) together with eight philosophically informed dimensions of humanisation (Table 1), as providing the stepping stones towards achieving humanised care, arguing that the humanising dimensions' illuminate and give direction to how we understand people as well as provide a structure for analysing and understanding the human condition (Galvin and Todres, 2013, White and Tait, 2019).

[insert Table 1 here]

In the educational institution where the study took place, the concept of lifeworld-led care and the HVF provided an ontological and epistemological understanding of the experience of health and illness. Whilst not a nursing model or curriculum framework, it offers nurses an opportunity to understand the supporting structures and challenges that face all individuals in their experience of being human (Scammell and Tait, 2014). This was achieved through

reflecting on and embedding a culture of humanised care at an individual, team and faculty level that emerged from a "bottom-up" approach to change. The strength of this was the natural congruence between personal and professional values and beliefs when delivering a humanising message. This was demonstrated by integrating the humanising values approach into the practice of education prior to and at the point of students commencing the course. A spiral approach embedded the concepts into the curriculum, and application to practice embedded by working with practice partners.

Methodology

The aim of the research was to develop a deeper understanding of how nursing students described their values and their perceptions of the factors that influenced those values as they progressed through a humanising philosophy-based nursing curriculum.

Research question:

> *How do nursing students experience, describe and interpret their values when exposed to a curriculum based on humanising philosophy?*

Design

This longitudinal study commenced in 2013 prior to start of programme and completed in 2016 when the students' programme finished. The sample comprised one cohort of nursing students (UK – adult field) (n =180) (hereafter called students) undertaking a three-year full-time undergraduate pre-registration nursing programme plus nursing lecturers (n=3) who acted as co-researchers and participants. The Faculty and Programme Leader acted as gatekeepers to the project and permission was sought from the gatekeepers as part of the ethical approval process. The research was informed by co-operative inquiry; a participatory action research approach where researchers and students, reflected on their experiences and offered feedback during the process (Reason, 1988; Kemmis and McTaggart, 2005;

Heron and Reason, 2008). Figure 1 maps the research process. The underpinning research philosophy is based on inviting and involving the 'community' in identification of what is valued, problems and challenges encountered and how these may be overcome (Carr and Kemmis, 1986). For Reason (1988, p. 1) "co-operative inquiry is… a form of education, personal development and social action". The value of knowledge focuses on how to flourish through co-operation, sharing autonomy, responsibility and action (Heron and Reason, 1997).

[Insert figure 1 here]

In this study, the challenge of using a co-operative approach was to encourage participation and collaborative working while balancing the lecturer-student relationship so that participants avoid becoming resistant or intimidated by each other's contribution. Kasl and Yorks (2010) state that this approach promotes a shared view of commitment and supports participants to maintain this and motivation to achieve an end point. According to Pring (2002), ensuring a focus on the virtues of educational research supports intellectual and pragmatic interests in a co-operative inquiry. This includes focusing on interdependence, individual accountability, supporting individual and collective success, trusting relationships, and nurturing openness and constructive criticism. In this study all contributors declared a vested interest in the research and actively supported the educative and collaborative nature of action research. These principles are consistent with the humanising values framework (Galvin and Todres, 2013).

Data collection

Data collection methods comprised a Values Clarification Exercise (VCE) questionnaire, focus groups and co-operative inquiry groups. Table 2 maps use and response rates. The VCE questionnaire (table 3), was adapted from Manley (2000).

[Insert Tables 2 and 3 here]

This approach aimed to obtain qualitative data inductively based on participants' personal perspectives rather than presenting a prescribed list of value statements. Stage one (year one) findings are reported in depth in Scammell et al., (2017). In year two the VCE was repeated and findings presented to focus groups (FG). FG data were audio-recorded and transcribed. At the end of their programme students were invited to attend co-operative inquiry groups where VCE and FG findings were presented. Students then wrote responses to five questions which had been developed from the on-going analysis:

1. *Have the themes identified in years 1 and 2 changed in year 3 and if so how?*

2. *Have you experienced any new challenges apart from those experienced in year 2?*

3. *Have you built your resilience and if so how?*

4. *How does it feel to be part of this co-operative study?*

5. *Were there any key moments or situations that helped with embedding your values?*

Ethical considerations

University research ethics approval was secured together with permission from the gatekeepers. At each stage of the project, a participant information sheet was sent to each student and informed consent obtained prior to data collection taking place. Findings were kept secure and shared only by the research team and co-operative inquiry group.

Data analysis

Data were analysed at each stage of the research using inductive manifest content analysis (IMCA) described by Graneheim and Lundman, (2003). This involved categorisation of the meaning units from analysis of the value clarification statements, focus groups, and co-operative inquiry groups to identify subthemes and overarching themes. The VCE questionnaire provided 161 responses from year one and 56 responses from year two. Both sets of data were analysed independently and separately using IMCA after which findings

from year 1 were compared with those from year 2. Findings from the two cycles of VCE were presented to students in FGs where, drawing from their course experiences they analysed the themes and factors influencing their practice. The researchers then analysed FG findings to reveal changes to the themes. The overarching themes that emerged were presented to the students in co-operative inquiry groups in their final year. This completed the action cycle as the students and lecturer participants engaged in "making sense" of their experience (Reason, 1988, p. 37). The meaning units and overarching themes were then compared with the findings from years one and two to map evolving student values as they travelled through the programme.

Findings

Students were predominantly female (81.5%), aged 18 – 44 years. Pre-course care experience ranged from zero to several years as a Health Care Support Worker. Stage 1 discussed by Scammel et al., (2017) identified that 89% (n=161) of the cohort completed the VCE. At the beginning of year two the continuing 156 students were invited to complete the VCE again, and 53% (n=82) completed the questionnaire (stage 2). Of the 82 students, 31 (38%) agreed to take part in focus groups. In stage three 131 students (that is those who had completed the programme) were invited in groups to analyse the findings and reflect on how the process had informed their values (see table 2).

Emerging themes reflected the evolving nature of experiences and expectations as students moved from idealistic ideas to realities of professional practice (illustrated in figures 2-4). At the point of entry to the nursing programme (stage 1 / year 1) five themes were identified (see figure 2 and detailed in paper by Scammell et al., 2017). These we categorised as *'Ideals and Aspirations'*. At the start of year 2 (stage 2) emerging themes were presented to focus groups. Analysis indicated that categories had moved to *'Reality and Uncertainty'*. At the end of year 3 (stage 3) the overarching themes from stage 2 were represented to final

year students and discussions identified that they had embodied *'Living with the humanised care approach'*.

[Insert figure 2 & 3 & 4 here]

Theme: How I want Care to be (identified in stage 1) evolved to the more realistic perception of **How care is** (stage 2 and 3). Students reflected how inadequate staff numbers impacted on quality time with patients: *'sometimes you are rushed and expected to do too much'* (FG2). They coped by '*remembering why I became a nurse*' (FG2); and '*my values remain the same but we understand them more now*' because '*being at university has helped to build on them*' (FG3). However, they spoke of upholding values being challenging due to organisational factors and needing to '*fit in*' (FG1), because '*if you challenged people it impacts negatively*' (FG2). They spoke of finding it hard to say "*That's not right. I'm not doing that*" *and slipping into* [poor practice] (FG1).

Stage 3 themes (figure 4) evolved as students progressed through the programme and gained more clinical practice experience. Student responses moved from articulating concerns regarding time constraints and pressures of professional socialisation, to feeling valued as a team member. Growing confidence is evident from stories of proactively acting as patients' advocates as they '*learnt to engage with other professionals*' and how *'care has evolved'*. They spoke of how '*receiving thanks from patient and families reminded me of the importance of our job'* concluding how feeling valued enabled learning and ability to '*challenge the culture of nursing*'

Theme: Value of Learning identified in stage 1 evolved into **Learning to Nurse** in stage 2 and then **Being a Nurse** in stage 3. In stage 1 they spoke of wishing '*to give holistic care'* (student 114); '*enhancing knowledge and understanding* (student 144). In stage 2 they felt that by being exposed to '*greater knowledge',* and *'how learning new skills and research*

boosts confidence' (FG2). They spoke of how '*If your mentor is interested in you, you're focused and learn more'* enabling them to '*challenge care'* (FG4). In stage 3 they demonstrated more confidence, knowledge and understanding which enabled '*reflection'* and control. They articulated achieving their dreams, as experiences of '*manage[ing] own case load'*, '*delegating and leading,'* dealing with '*stress'* and '*bereavement'* helped build confidence. They spoke about personal resilience growing as they were supported to '*talk[ed] about worries'*, and '*understanding that you cannot fix everything'.*

Theme: Perceived characteristics of a nurse moved from dreams about being to '*help others'* and '*make a difference'* in stage 1*,* to upholding these and '*practising confident, evidenced-based care'* (FG3). At the end of the programme students spoke about being confident, evidence-based practitioners, ably identifying uncaring nurses '*You feel quite angry towards the person …. I felt why are you here? You don't show care and compassion'.*

Theme: Building resilience was expressed by students in stages 2 and 3. Students described challenges of '*time constraints'* and being unable to '*always give the care I wanted to give'* (FG4); the need to '*fit[ing] in and conform[ing]'* (FG1); difficulty challenging *'house politics'* (FG1); '*frustration'*, '*extreme tiredness'* and '*loss of compassion* (FG2) and '*knowledge gaps'*. Yet despite these difficulties they articulated the need to build resilience in order to '*cope with the challenges'* (FG4).

Theme: Respecting humanity was key to their practice throughout their programme. By the end of the programme respecting humanity was key to offering **Humanising Care.** In stage 2 students' articulated that to respect humanity they needed '*emotional intelligence'* and to '*draw on your life experience'* (FG3). They spoke of establishing effective therapeutic relationships and offering clients choices. To do this they tried to understand issues from a patient perspective: '*sometimes it's difficult to build a therapeutic relationship but you keep working on it'*; '*I nursed a patient in the hospital and in the community and he was a different*

person. He said that hospital was like a prison and was alien to him and he was better at home' (FG3). Respecting humanity and humanising care was more personally embedded: to '*understand it is the small changes that make the biggest difference to people',* feeling valued themselves through seeing '*patient satisfaction'.* Final year students also articulated that being part of this longitudinal research project felt '*rewarding'*, because they felt they were '*being listened to*', and were a '*catalyst for change*' by '*help[ing] future nurses*'.

Findings indicated student dedication to upholding values articulated on programme entry and they developed strategies to manage factors that compromised value-based care. By stage 2 they recognised the innate nature of values and critiqued the challenges of application in clinical practice: '*..we come back to the values, I feel so much compassion I want to change everything I do*' (FG2). Final year students reflected how challenges were opportunities: '*Values have not changed. I have become more in control*'; '*nursing is a privilege';* '*knowledge, experience and exposure to different situations informs opinions and practice'.* Students told of key moments when embedding of values were enhanced and by *,* '*having a good role model'* they could '*build up a strong relationships*'.

Discussion

This study has provided a rare insight into the evolving professional values of nursing students as they journeyed through their pre-registration nurse programme. Ideals and aspirations (figure 2) were challenged after students first practice experience as they focused on learning practical skills. However, they described how some professionals were uncaring and articulated how they want care to be and how the reality caused frustration and anxiety. This cognitive dissonance (the state of having inconsistent thoughts, beliefs, or attitudes) is consistent with previous studies on caring (Lukose, 2011; Vandenhouten et al., 2012; Coe and Fulton 2016), who highlighted caring as a fundamental human attribute, embracing humanity, which not only focuses on patients signs, symptoms but also connecting to the person in a deep rich way. Adams (2016, p. 2) explored the 'conundrum of

caring' as nurses struggled to uphold the 'complex abstractness of caring which transcends the material and phenomenal world' as technology and workforce pressures dominate. deVries and Timmins (2017) label this as care erosion.

Health care is complex, stressful and challenging. To survive and minimise burnout, resilience is crucial (McGowan and Murray, 2016; Lopez et al., 2018; Cleary et al., 2018; Amstrud et al., 2019). These studies indicate that students are anxious, worried, fatigued, stressed, depressed and struggling to cope. Alshahrani et al., (2018) describe how nursing students lack of skills, knowledge, effective communication strategies, self-confidence and fear of making mistakes and not meeting expectations, led to high levels of stress and attrition. They note that a 'supportive environment with constructive attitudes helped enhance coping in placement' (p. 105), a finding supported by our study.

Sanderson and Brewer's (2017) literature review stressed the need to enhance resilience in health professional education (resilience being the ability to turn to normalcy from adversity and having a positive outlook). Our study revealed how year 2 students articulated 'learning how to care', 'how they wanted care to be' and 'resilience' (Figure 3) as key to success, and ability to cope with uncertainty. Cognitive dissonance related to witnessing uncaring staff which challenged their own behaviour and attitudes to change. The humanising curriculum facilitated discussion of these issues in university-based reflective days during placements, with lecturers and peers as well as study modules which explored humanising nursing care and evidence-based practice. As students progressed they started to live the humanised approach to care, learning how to live with uncertainly, develop coping strategies and becoming resilient to cope with difficult situations including challenging health care professionals.

Drawing on Galvin and Todres' (2013) lifeworld approach, the concept of embodiment (Table 1) links to findings from stage 1 (Figure 2), the study showed students identifying with values

and dreams of being a nurse albeit their embodied values had yet to experience practice realities. In stage 2 (Figure 3), the study identified that students started learning how to face practice challenges and the difference between 'how I want care to be' and 'how care is'. However, they saw humanity as central to this as they built resilience and 'learnt how to nurse'. By stage 3 (Figure 4) they had learnt how to live their values, challenge others and embodied humanising values as they internalised and disseminated a humanised and person-centred approach to care.

A decade of theoretical literature concerning the body and embodiment gives insights into nursing practice and predominantly focuses on empirical investigation of the body. However, the embodiment in nursing remained relatively neglected. Draper (2014) explored this and argued that the domination of scientific and medical epistemologies of the body have displaced and marginalised embodied epistemologies creating a limited understanding of the embodied experiences of nurses. Galvin and Todres (2013, p. 18) explored personification as a humanising dimension and how humans 'live within the fragile limits of human embodiment', suggesting movement between taking a reductionist view of reacting to signs and symptoms and thoughtfully responding to others. Sakalys (2007) highlighted that embodiment is the central focus of caring requiring nurses to attend to the primacy of the embodiment of patients' experiences. Todres et al., (2009) and Galvin (2010) argue that for nurses to respond to the human dimensions they need to embrace 'head', 'heart' and 'hand' concepts and embed the science of caring into offering humanly sensitive nursing care. We suggest that to do this students need emotional intelligence (EI) and ability to eloquently challenge (Raghubir, 2018) poor practice or suboptimal care. Michelangelo's (2015, p. 123) meta-analysis found that EI is valuable because it 'improves emotional competence, critical thinking, leadership, caring, ethical behaviour, reflection…. and performance'. Raghubir (2018) suggested that four common attributes of EI are self-awareness, self-management, social, awareness and social/relationship management. Consequently, EI is essential to nursing practice, critical thinking and ethical decision making and needs to be embedded in

nurse education. Our findings suggest that reflecting on practice, examining the evidence base underpinning practice and understanding humanised care students developed EI attributes. However, emotional dissonance and moral distress occurred when there was conflict between pressure to conform to rules, and distress felt when seeing dehumanised care. We suggest that as students built resilience and EI, they developed strategies to cope with challenging suboptimal care giving through the embodiment of humanising values.

Limitations of study

Caution is required as participants were drawn from one cohort in one university in England and transferability is subjective. Participants completed the VCE online before meeting lecturing staff and whilst reducing the risk of the power differential impacting on responses, perceived pressure to respond positively and complete may have been high. Perceptions of power may have continued and students participating in focus groups may have been the more vocal than a 'silent majority' who felt unable to voice opinion, thus questioning validity. Co-operative inquiry and the concept of researching *'with'* rather than '*on*' people has strengths and limitations. One limitation is perceptions of power as relationships are fundamental to the creation of reality and the ontologically power imbalance of lecturer (as researcher) and student (as participant) may invalidate findings and knowledge created. Indeed, students, being concerned that contributions would influence assessment grades, leads to social desirability bias where participants record what they think researchers want (Robling et al., 2010).

Conclusion

This study provides insight into the evolving professional values of nursing students as they journey through pre-registration education and contributes to the co-operative inquiry and nursing bodies of knowledge. This study found that students drew on their personal lifeworld to express their values about nursing on entry to the programme and these were idealistic about personal values for person-centred practice; however, disillusionment around the

realities and pressures of care occurred and compromised their values. Nevertheless, students found what internalisation of person-centred practice means and developed an understanding that this needs to be lived as their way of being. The spiral curriculum approach enabled students to revisit the humanising concepts at individual, group and organisational level as they were exposed to clinical practice. During clinical practice, staff appeared to scaffold and support students to accommodate reality whilst students retained their value base for practice and built resilience. Personal values were upheld by students as they advocated nursing as a discipline despite conflict and challenges. This suggests that humanising nurse education can enable students to recognise humanity in themselves and others and embody humanising values as a way of being. Future research is needed to establish if participants of this study continued to uphold their humanising value base as qualified nursing staff.

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