

**What is the influence of clinical experience on the nursing  
student's understanding of patient centered care?**

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A thesis submitted in fulfilment of the  
Requirements for the degree of

**Master of Clinical Science**

Faculty of Health Sciences

School of Nursing

University of Adelaide

2017

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**Signed Statement:**

**Candidates Declaration**

I declare that this thesis is the result of my own research, that it does not incorporate without acknowledgement any material submitted for a degree or diploma in any other tertiary institution and to the best of my knowledge and belief contains no material previously published or written by another person, except where due reference has been made in the text.

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Date: 27/02/2017

## Acknowledgements

I wish to acknowledge Associate Professor Lynette Cusack and Dr Frank Donnelly, my supervisors for their endless patience and support during this research.

I also acknowledge the students who participated in this research and willingly gave up their time to be interviewed.

Finally, I wish to acknowledge the support of my husband, Craig Battams who offered endless words of encouragement and support throughout the research and writing of this thesis.

## Abbreviations:

- PCC Patient Centred Care
- CST Critical Social Theory
- AHPRA Australian Health Practitioner Regulation Agency
- ANMAC Australian Nursing & Midwifery Accreditation Council

## Abstract

This qualitative study investigated the student nurse experience of clinical placement and the effect the environment and existing culture had on their ability to deliver patient centred care using critical social theory. The central aim of the research was to understand the social and contextual influences of clinical placement that may impact on the student's ability to bridge the theory to practice gap and provide holistic and patient centered care.

The term "patient centred care" has now become central to nursing dialogue and teaching. To be patient centred means that nurses need to engage with the patient and their family taking into account their beliefs, values & feelings. In addition to this, they must share the decision making with the patient and provide the physical needs essential to promoting a healthy outcome. This level of engagement is a significant expectation for nurses entering the workforce. However, evidence suggests that many nursing students are still required by the workplace to focus on the completion of tasks rather than spending time engaging with patients as central to their care.

Using critical social theory as the theoretical framework, focus group discussions involving three groups of third year nursing students (n=31) were conducted. The participants provided a rich source of data that detailed their experiences of clinical placement over the three years of their Bachelor of Nursing degree. The value of this research came from the comparisons made between the environments that students considered as either enhancing or



eroding the level of patient engagement. It was through a reflective process that the major themes emerged from this study:

- The importance of belonging
- Socialisation and the influence of experience
- Being valued

In undergraduate nursing programs today it is important to develop nurses who have caring and holistic practice at the forefront of their role. To do this effectively we as educators must know and understand the effect socialisation has on students attending clinical placement and to set about a process of change with our colleagues in the clinical work environment that shifts their assumptions on the role of the student nurse from a task orientated add-on to a developing practitioner who is valued as part of the health care team

## Chapter 1

### Research Question

- *What is the influence of clinical experience on the nursing student's understanding of patient centered care?*

### Introduction

The term "Patient centred care" (PCC) has become central to nursing dialogue and teaching. To be patient centred means that nurses need to engage with a patient's family, respect their beliefs and values, understand the patient's feelings, share the decision making with the patient and provide the physical needs essential to promoting a healthy outcome for the patient (McCormack & McCance 2010).

The purpose of this chapter is to present an overview of the research project. The concept of Patient Centred Care is defined and its relevance and importance to both patients and care providers is established. It is important to note that the term "patient centred" will be used throughout this thesis as it is often used in the literature interchangeably with person centred, client centred, relationship centred and resident centred. This variance tends to depend on the contexts of care provision however all terms essentially advocate for the individualised care of a person regardless of the health care setting (Morgan & Yoder 2012). The term "patient" has been chosen, as this is the term most widely used and recognisable to the students involved in this study.

## **Patient Centred Care**

Patient centred care is currently valued by most healthcare systems and is taught as a concept in most nursing education programs today. The term patient centred care implies that the focus of care is the 'patient' and that they will be involved in the decision making of all interventions or care initiatives. In 2010, the Australian Commission on Safety and Quality in Healthcare put forward a proposal called the National Safety and Quality Framework which highlighted that the most important dimension required for a safe and high quality health system was 'patient centred care.' This framework was developed and based on interviews with patients, consumers, carers, clinicians, managers and policy makers. This framework highlights the benefits of a PCC approach in health care, which include an increase in quality, and safety of health care, decrease in costs and an increase in provider and patient satisfaction.

## **Context and Statement of the Issue**

Effective patient centered care in community and acute health care settings is now a widely held ethos by many professional groups and particularly by nursing (Benner et al. 2009). According to Benner et al. the philosophy of PCC is now taught in most English speaking nursing programs world-wide and the terms patient centred care and person centered care are now recognised and valued by most healthcare providers (Benner et al. 2009).

Research conducted by Currie et al. (2015) observing how first year nursing

students begin to learn about person centered care found that although the concepts of PCC had been embraced by the participants they described the difficulties they experienced and observed in practice in the application of this approach to nursing care (Currie et al. 2015) These findings concur within this current research where the students explained that the application of PCC in the clinical setting is often hindered by the need to get tasks done in a timely fashion and that not all clinical settings provide the support or mentoring required to foster a patient centred approach to care.

The engagement of patients and their families in the decision making of their own health care has been a long-standing issue for health care professionals. This is due to the challenges of developing patient centered nursing and the attitudinal and organizational barriers that can hinder such an approach. The National competency standards for registered nurses (Nursing and Midwifery Board of Australia 2016), states that nurses must adhere to a collaborative and therapeutic practice. This involves establishing, sustaining and concluding professional relationships with individuals and groups. Whilst it is accepted that the responsibility of the quality of care rests with the individual nurse, change in service delivery must also take place from an organisational, and a strategic level if nurses are to be supported in holistic practice (Australian Nursing & Midwifery Federation 2016).

This study explored the influence clinical experience had on third year nursing student's perception of patient centered care. The study was situated in the University of Adelaide Bachelor of Nursing program where a "theory to practice" ideology is embedded in the curriculum.

### **Research Question**

This research focused on third year student nurses experience in clinical placement and in particular the effect the environment and existing culture had on their ability to understand PCC. The central aim of the research was to understand the social and contextual influences of clinical placement that may impact on the student's ability to bridge the theory to practice gap and provide the holistic and patient centered care that is promoted as the ideal in their studies as trainee nurses.

The research question arising from the intent of this study and review of the literature is.

*What is the influence of clinical experience on the nursing student's understanding of patient centered care?*

The theoretical framework that underpins this research is framed within a critical social theory paradigm. "Critical social theory has been described as an approach for critiquing existing conditions for the purpose of enhancing individual autonomy and responsibility" (Wilson-Thomas, 1995 p 572). This research approach argues that individuals exist within and their actions are

informed by particular social and organizational contexts. Individuals need to be aware of this context, understand how it impacts on them so as to act with greater autonomy.

## **Aims**

The aim of this research is to understand the social and contextual influences of clinical placement that may impact on the nursing students' ability to provide PCC. This research will explore the experiences of student nurses who practice in a broad range of clinical venues and not exclusively hospital environments.

## **Objectives**

- To describe how and to what extent patient centred care as the central nursing theory has been built into the Bachelor of Nursing curriculum.
- To understand how nursing students reflect on the patient centred care approach that the curriculum has implied.
- To explore how and to what extent nursing students reflect and analyse the impact of the clinical placement environment on how they apply patient centred care.
- To identify the strategies nursing students use to enable them to deliver patient centred care while on clinical placement given the context they work in.

## **Significance of the research**

This research is important to education providers, placement providers, student nurses and patients, as it provides insights into the real life workplace experiences of a particular cohort of student nurses immediately prior to joining the workforce. The intention is to assist these stakeholders to understand how university and workplace learning have informed the student's understandings of patient centered care. These findings will provide important input into ongoing curriculum development and clinical supervision, and nursing practice, particularly as this relates to understanding the interrelationship between university and workplace learning to improve student preparation for professional practice.

If the vision of the nursing profession is to develop nurses who have caring and holistic practice at the forefront of their role, then it was important for this study to establish if this vision is contrary to the reality of everyday practice of clinical placement. The value of this research was in the comparisons made of the students' experience as they reflected on the social and cultural and environmental impacts that either enhanced or inhibited their ability to provide PCC.

## **Assumptions and limitations of the study**

The data elicited from the students provided valuable insights into their experiences and highlighted some issues concerning PCC as it appears in practice. The assumption made in this study was that all students who volunteered for the focus group interviews would be open and honest with their

responses. It is acknowledged however that these views are from students from one education institution and one-year level therefore comment and comparisons cannot be made about how these insights may have changed over time.

## **Definition of Terms**

### ***Patient / Person centered care***

No clear definition exists for 'Patient Centered Care' however McCormack and McCance (2006) describe person/patient centred nursing as including working with the patient's beliefs and values, having sympathetic presence, sharing and engaging with patients in the decision making process of providing physical and emotional care.

### ***Critical Social Theory***

Critical social theory examines the patterns of human behaviour along with the existing social structures and communication processes, which define them (Linda 1995).

### ***Theory to practice***

"The clinical nurse is not only a practitioner, but a theorist and researcher, who responds to patients, not according to some grand, inflexible theory, but by the process of reflection-in-action, drawing upon their expertise and a repertoire of past experiences and encounters" (Rolfe 1993).



## **Summary of the Thesis**

### *Chapter 1.*

#### Introduction

The introduction to this thesis explains to the reader the primary focus and purpose of this research project. The research question is clearly defined and the process this research has taken was clear and achievable. The significance of this study is examined from the perspective that it will inform future teaching strategies and changes to curriculum that will both inform and support nursing students as they strive for a more patient centered care approach to their nursing practice.

### *Chapter 2.*

#### Literature Review

This literature review has been divided into three components that support and inform this study. The first component will explore the meanings of PCC from some early definitions dating back to Florence Nightingale in the 1840's. The second component of the review will consider the impact that professional socialisation has on the working environment for nurses in the health care setting. The final component will focus on the nursing students' experience of patient centered care in practice and on how they negotiate this in the complex health care environment. An ongoing literature review has been in progress throughout the writing of this thesis.

### *Chapter 3*

#### Methodology

The methodology chapter describes the methods and processes by which the study was developed. This chapter will define what a methodology is and why one is required for research. It will describe why critical social theory was the most appropriate methodology to explore the student experience in the real world of practice. Citing the works of German critical theorists such as Max Horkheimer, Herbert Marcuse, Theodore Adorno, Friedrich Pollock, Erich Fromm, Franz Neumann and Leo Lowenthal the formation of this school of thought will be discussed. Critical social theory as applied to nursing education and practice will be explored and the value of this approach will be clearly stated.

### *Chapter 4*

#### Methods

The methods chapter presents the major elements that comprise the process of this study. As I was interested in what the students knew and practiced in terms of patient centred care, I was also interested in identifying if PCC terminology is used within the course content of the Bachelor of Nursing Program. The first stage of this research project therefore was to conduct a curriculum mapping exercise looking at the course profiles across 24 courses taught in the nursing degree. The second stage of the project was to conduct focus group discussions with student nurses enrolled in third year. Here the selection of participants, study setting, and inclusion and exclusion criteria are

discussed. Ethical considerations are explored and the issue of rigour in relation to qualitative research is noted.

## **Chapter 5.**

### **Analysis**

This study utilised Qualitative Research Methods framed within a Critical Social Theory paradigm to understand how a group of third year nursing students conceptualised and practiced a patient centred approach to care in the real world of nursing. Thematic analysis was applied to the focus group data to arrive at four main themes, which summarise the understandings and experiences of the student nurses under study. The researcher then sought to interpret these experiences and to understand the deeper meaning as it emerged.

## **Chapter 6.**

### **Interpretation**

A core group of themes resulted from the thematic analysis, which were then interpreted to add meaning and to draw some conclusions from the student nurses' placement experiences. The themes that emerged were 'Conceptualising patient centred care', 'The essentialness of leadership', team and culture, 'Meaningful work and Making a difference'.

## **Chapter 7.**

### **Final Chapter – Discussion and conclusion**

This chapter draws together the main issues that have arisen from this study. The findings are analysed from a critical social theory perspective to explain the lived experience of student nurses in their understanding and application of

PCC. The limitations to this study are outlined and suggestions for further research are offered.

## Chapter 2

### Literature Review

#### Introduction

This chapter will present a synthesis of the literature surrounding the social and contextual influences of clinical placement that may impact on the third year student nurses' ability to bridge the theory to practice gap and provide holistic and patient centred care. The primary focus of the review will be to identify and critically appraise literature concerned with patient centred care, the influence of socialisation and the place of critical social theory in the conduct of nursing research. The literature review will identify gaps in the literature that support the need for studies such as this.

#### Search terms, databases and logic grid

A search of relevant literature was conducted using the following search terms: The search terms were used within a number of databases including PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus and Embase. Search terms were restricted to English language publications but there was no restriction on time as further research into earlier publications was required to explore the historical beginnings of PCC. Search terms used were "Patient centred care" "Patient centered Care" "Person Centred Care" "Person centered care" "Student nurse experience" Socialisation of student nurses" "Critical Social Theory" "Critical Social Theory". In the later stages of this thesis more recent publications on PCC were sought to inform the

discussion. The terms were used in an automated database search engine that provided an ongoing literature review throughout the writing of the thesis.

### **Describing Patient Centred Care**

The concept of Patient Centred Care has a long history in health care and origins of this concept are thought to have come from Florence Nightingale who focused on the patient and not the disease (Lauver et al. 2002). An American psychologist Carl Rogers expanded on this notion of “person centeredness” in the 1940’s, his principle theory was that each individual possesses considerable qualities, which enables them to draw strength from available resources and to find a remedy for any difficulties (Rogers 2012).

There have been many definitions put forward in an attempt to describe Patient Centred Care however there is no single definition that has been accepted by all health care professionals and organisations. In an attempt to define what PCC means to nurses Levett-Jones (2010) explains:

“A holistic approach to the planning and delivery of healthcare that is grounded in a philosophy of personhood” (Levett-Jones & Bourgeois 2010)

Patient centred medicine was a concept put forward by Balint in the 1960’s to suggest how physicians should interact with their patients (Balint 1968). Balint described two classes of pathological conditions, one where a scientific examination is made to diagnose an illness or fault in the body and then to treat this accordingly. This is called “illness-orientated medicine” The second

approach is to utilize a more “patient centred approach” where the illness is localized by examining the whole person bringing together everything the doctor knows and understands about the patient. At the time this caused some conflict amongst the medical profession who thought that the aim was to turn them into minor psychiatrists (Balint 1968).

Since Balint several authors have built on his research and multiple dimensions have been proposed. Lipkin Jr, Quill and Napodano (1984) suggest that a practitioner who is truly patient centred must have a basic knowledge, skill and attitude to provide PCC. They propose that patient interviews should be conducted so that the patient can share his or her unique story whilst promoting trust and confidence, clarifying concerns, generating and testing hypotheses and overall, creating the trust required for a genuine and ongoing relationship (Lipkin Jr, Quill & Napodano 1984). The interview is also important when attributed to the nurse, patient relationship where the development of trust and the therapeutic relationship is also observed as a means to provide PCC.

Since these early references, the concept of PCC has become well established in health care delivery and especially within nursing policy development. McCormack (2004) conducted a comprehensive literature review revealing 110 papers, which related to aspects of person-centred practice mostly originating from the UK. McCormack noted that whilst most of the theory and practice of PCC were taking place in the UK there were commonalities with other international nursing perspectives such as the ‘Synergy Model’ (Curley 1998) and a model of ‘family centred care’ (Wilson, McCormack & Ives 2005) and ‘Quality Health Outcomes Model’ (Mitchell et al. 1998; Radwin & Fawcett 2002).

When examining the literature, Robinson revealed four different classifications for defining PCC; economic, public policy, clinical and patient perspective (Robinson et al. 2008). Each of these definitions is of equal importance to the delivery of patient centred care. Whilst public policy perspectives measure health care quality and help to shape the vision for health care, the economic perspective recognises the patient's ability to make informed healthcare choices around cost, convenience and quality. Of equal importance is the clinical practice and patient perspective where the clinical definition tailors the treatment to the patients' needs and the patient perspective looks at those needs and preferences from the patient's point of view (Robinson et al. 2008)

According to Robinson et al. (2008), the lack of a consistent definition and method to measure PCC has hampered its implementation. In a review of the relevant literature, she found that patient centred interaction leads to improved health outcomes and promotes adherence to treatment, but that the fundamental characteristics of PCC remained unclear.

Earlier research into patient centeredness attempted to clarify the meaning of the term, to explore its implications in practice, and to determine the contextual and cultural challenges to implementing a patient centred approach (McCormack 2004 and Binnie 1999). Binnie (1999), suggested that a patient centred approach provided more holistic care and increased patient satisfaction. They discussed that PCC may also reduce the anxiety levels of nurses and promote teamwork amongst staff.



Ponte et al. (2003), describes some of the factors, which slow the implementation of PCC as being related to the difficulty for some clinicians to change traditional patterns of interacting with patients. There is also the belief that to provide PCC will increase both the time and cost of care (Mead & Bower 2000). This inability to define and measure what it means to provide PCC has possibly decreased its scientific utility and has impeded the ability to advance research in this field. Within the scope of the literature, review there has not been any research conducted to identify and measure these outcomes for both patients and nurses nor has any research directly examined the impact of socialisation of student's application of PCC.

### **Professional Socialisation**

To be able to recognise the impact of socialisation on the nursing profession and on the student nurse, a study by Wyatt in 1978 in a study looking at the effects of socialisation into a profession involving nursing students. Qualitative research methodology involving focus group discussions examined nurse training in the UK where students attended study blocks and then worked for minimal wages in hospital wards. Twenty-seven nursing students and six nursing tutors were interviewed, focusing on the way nurses give meaning to the educational experiences provided for them. A number of issues arose from this research however a central theme persisted which was that there was a tension between theory and practice that influenced students when 'caring' for patients whilst learning (Wyatt 1978).

Many authors have attempted to define the term socialisation in relation to occupations (Becker 2002; Cohen 1981; Dingwall 2014; Morrison 1993; Olesen & Whittaker 1968). These early interpretations suggest a one-way process of socialisation where the student nurse must try to fit into the system and behave and act in a way that enables them to gain acceptance by adopting the occupational identity as deemed appropriate in a work setting. More recent research by Levett-Jones and Lathlean (2008) in a mixed method, multi-site case study looking at Belongingness and the Clinical Placement Experience puts forward the argument that whilst this one-way process still dominates in clinical practice, a sense of belongingness as a prerequisite for learning was the main theme that dominated in her study. The findings revealed that an absence of belonging caused students to feel alienated and anxious and that these feelings drew them away from becoming involved in experiential learning. The preoccupation with staff interpersonal relationships and trying to fit in had a lasting impact on the nursing students' confidence, which impeded their ability to question and to progress their learning (Levett-Jones & Lathlean 2008).

If this is how student nurses interpret the clinical environment, it is necessary to look at the influences in the clinical settings that do not foster this sense of belongingness and focus solely on tasks and competencies. Levett-Jones and Lathlean (2008) points out that simply undertaking clinical placement does not develop competence nor does it guarantee learning.

It is acknowledged that the socialisation process can have both positive and negative consequences for the professional development of the nursing student; however the most predominantly documented consequences are

negative outcomes such as the lack of critical awareness, ritualised practice and adherence to long held traditional views (Ashworth & Morrison 1989). Morrison (1993), in a longitudinal involving 135 new staff accountants describes the stages of socialisation begin with the newcomer firstly being reactive and then responding to organisational and cognitive processes to become socialised. The final stage is when the newcomer is proactive and can adjust to their new environment, using their initiative and not relying on just being driven by the needs of the organisation.

A more recent study was carried out by Dingwall (2014) into the professional socialisation of what he terms 'health visitors'. Dingwall's definition acknowledged that the socialisation process might be uncertain but that students can have an active rather than passive role in this. He describes how the student initially must make sense of their surroundings to acquire knowledge to produce behaviours that can be recognised as competence.

Melia (1987), in an early discussion on this topic describes how the socialisation of student nurses is experienced in two situations, one in the classroom and one in practice. This she says can create some confusion for the student nurse, as often what is taught may not be what is experienced in practice, which can result in a lack of commitment to both the classroom and the clinical environment. Smith (1992), supports this theory and suggests that students often start out as enthusiastic and fresh but by the end of their studies they become cynical and disillusioned and less able to engage with patients in the clinical environment. Maben, Latter and Clark (2007) explains that this disillusionment may be caused by the divide between their ideals for practice

and the reality of coping with the demands of clinical practice which can in turn lead to feelings of personal disappointment and professional dissatisfaction.

Seminal works conducted in the UK and USA over 30 years ago examined the extent to which nurses managed their ideals for nursing and the constraints of practice (Bendall 2006; Kramer 1975; Melia 1987). Kramer (1975) identified that nurses experienced “reality shock” when entering the workforce due to the disparity between their idealised role conception as taught in their studies and the role they found in the workplace. The reality they faced was far removed from the autonomous, individualised and personalised care they were taught to perform in their nursing studies. Practice in the workplace was broken down into tasks, procedures, and care that became impersonalised.

Kramer (1975) is further supported by Melia (1987) who found that student nurses were expected to be quick at tasks, to not ask questions, have a tidy ward and to always look busy. A more recent study by Henderson (2002) reflected similar findings describing the reality of entering the workforce as “utilitarian”, suggesting that nurses are prevented from giving holistic care to their patients due to the number of tasks to be completed in any one nursing shift.

In contemporary health services today, care delivery is often concerned with performance management, increasing patient turnover and managing the increased nursing workload. Over the past decade the demands on the nursing role have increased significantly with more technical work once performed by

junior doctors now being the responsibility of the registered nurse (Duffield, Gardner & Catling-Paull 2008).

Nelson and Gordon (2006), propose that there is a 'crisis' surrounding the delivery of bedside care that is caused by clinical environments that do not allow time to practice hands on care to patients. In more recent times nursing academics have embraced and taught holistic practice to legitimise the profession and move away from the dominant medical model (Lawler 2006). Maben, Latter and Clark (2007), suggest that the emphasis on PCC and holistic practice may be the reason for the disconnect nurses experience in the practice environment where the curriculum may not reflect the true nature of the responsibilities faced in the Registered nurse role. They have argued that the emphasis on individualised, holistic care has become the dominant discourse in nursing academia and often at the expense of a greater focus on the challenging and often-routine work nurses do in the clinical environment. This they say leads to disillusioned nurses who often go on to leave the workforce.

A study conducted in Canada by Curtis, Horton and Smith (2012) looked at the 'Socialisation of student nurses in compassionate practice' and found that although the students came from diverse backgrounds they all expressed similar concerns and management strategies when on clinical placement. This research described that the student nurses found it hard to combine their personal commitments with study and clinical practice, which led to feelings of vulnerability and uncertainty. The students expressed a desire to practice kind, respectful and compassionate care but the reality of balancing this with the demands of practice left them feeling exhausted (Curtis, Horton & Smith 2012).

Research by (Zarshenas et al. 2014) determined that there were two categories that student nurses consider as important when entering the workforce. These are a sense of belonging and a professional identity. They found that if students were able to determine a sense of belonging that this resulted in acceptance of the profession. This present study supports the findings of Curtis as the Research findings describe an inconsistency with the academic demands and the demands of clinical practice. The students who participated in this current study described how the consistent management of these two learning methods was stressful and inhibited their ability to show themselves as a professional nurse.' In support of this contention a study by Jackson et al. (2011) reported that 95% of 105 third year students surveyed responded that they had feelings of anxiety and depression and were unhappy at the end of their nursing program due to inappropriate socialisation and lack of acceptance into the clinical workforce.

The study by Jackson et al. (2011) raises the question of how realistic this vision for compassionate care is when students have to constantly adapt their ideals just to survive the reality of practice. Curtis (2014) suggests that nurses require support from both educators and clinicians to develop resilience in their professional ideals. For this to occur O'Driscoll, Allan and Smith (2010) explains that those who work as University facilitators and those in the clinical environment need to recognise the dissonance that exists and work collaboratively to realign the reality of practice with the professional ideals of nurses.

The employment of appropriate clinical facilitators who can support and supervise the student nurse are pivotal to the new nurse experience. To enable students to identify with a colleague in the clinical environment promotes a sense of belonging and that a positive professional identity is critical for nurses if they are to achieve an effective standard of performance. This sense of identity will foster a positive patient environment, enhance job satisfaction and improve retention rates in nursing (Jackson et al. 2011).

### **Nursing Students Experience of Patient Centred Care**

Few studies have focused on the importance of assessing nursing student's attitudes towards PCC and the nurse patient relationship. McCarthy (2006), in an early study highlighted the divide between theory and practice in nursing with relation to PCC. She contends that within a PCC approach to health care there are three areas of conflict that exist, which are those between the demands of humanism, professionalism and health service providers. Humanism demands respect and autonomy for the patient, professionalism demands expert knowledge, skills and accountability while health care providers require the nursing care to be transparent and to reflect risk management principles. The ability to manage these demands and poor examination of the issues have therefore resulted in a fragmentation of care and frustrated nursing mentors who are overburdened with the result being poorly supported students (McCarthy 2006).

In a later and more recent study Currie et al. (2014) explored how first year student nurses begin to learn about person/patient centred care. Utilising a

thematic analysis and three focus group discussions (n=405) this study focused on documented, practice based, learning reports completed by the students following their six-week clinical placement at the end of first year. The findings of this study indicated that these students were aware of the concepts, principles and language associated with PCC. They identified the key components that contributed to this learning as receiving feedback and praise for facilitating PCC along with positive communication and dialogue with the preceptor which reinforce the principles of a PCC approach. Being encouraged to read patients notes and to formulate a care plan also helped to promote greater confidence and understanding of the individualised care required. However Fawcett and Rhynas (2014) suggest that a patient centred approach is not universal and that as students' progress to higher year level, tasks and skill acquisition take precedence. Patient centred care then becomes more difficult for nurses to perform due to time constraints, increased patient loads and acuity.

As nurses progress further into their education, standardised care pathways and paperwork can conflict with the notion of patient centeredness. Student nurses learn the importance of always putting the patient first, and under the guidance and supervision of the registered nurse, they develop the skills to be effective patient advocates, supporting families and designing individualised care plans. However whilst attempting to learn these new skills they are often faced with the significant task of ensuring patient safety and wellbeing whilst completing a myriad of essential activities, all which require accurate documentation (Fawcett & Rhynas 2014).



## Summary

This chapter has discussed the many definitions of PCC and its application. Kitson et al. (2013), describes patient centred healthcare as an approach that supports individuals to lead the life they want and the difficulty in finding one definition for PCC which includes all stakeholders, poses a problem for nursing practice. It is apparent that although core elements exist for all stakeholders, such as respecting patient choice and effective communication the lack of clarity has led to many different ways of practicing nursing care. In addition, four different classifications for defining PCC have been put forward; from the perspective of economic policy, public policy, clinical and patient perspective (Robinson, Callister, Berry & Dearing 2008). Whilst these classifications and definitions have been established as of equal importance to the delivery of PCC, there has not been any research to identify and measure the outcomes for both patients and nurses nor has any research directly examined the impact of socialisation on the nursing student's ability to deliver PCC.

A review of the literature has identified that the most predominately documented consequences of socialisation of student nurses is the negative outcomes such as the lack of critical awareness and ritualised practice. What is clear however is that socialisation into the clinical environment plays an important role in how student nurses engage and respond. What has been suggested is that a sense of belongingness is a prerequisite for learning and that an absence of this leads students to feel alienated and anxious which then draws them away from becoming involved in experiential learning. The preoccupation with trying to fit in can interfere with the students' ability to learn and practice PCC.

The following chapter will describe the qualitative research methodology chosen for this study and by utilising a critical social theory paradigm the researcher sought to understand the social and contextual influences of clinical placement that affected student nurses' ability to bridge the theory to practice gap to enable the provision of PCC.

## Chapter 3

### Methodology

#### Introduction

This study was conducted using a qualitative research methodology. The theoretical framework that underpins this research is framed within a 'Critical Social Theory' (CST) paradigm. This chapter will define what a methodology is and why one is required. The following sections will describe why critical social theory was the most appropriate methodology to explore how student nurses experience the real world of practice concerning the learning that takes place in the classroom and the implementation of patient centered care in the clinical environment.

#### Methodology defined

A methodology is a set of ideas or guidelines that give direction to the researcher in gathering and validating knowledge of a subject matter. The methodology comprises the theoretical analysis of the body of methods and principles associated with a branch of knowledge. This should not be confused with methods which are the techniques used for the conduct of the research (Orb, Eisenhauer & Wynaden 2001).

Cohen (1981), suggests that the aim of a research methodology is to describe and analyse the methods used to gather data which is to be used as a basis for inference and interpretation, throwing light on their limitations and resources, presuppositions and consequences. Thus a methodology seeks to help the

reader understand the research process itself (Orb, Eisenhauer & Wynaden 2001).

A qualitative paradigm was chosen based on the understanding that the social world can only be understood from the standpoint of the individuals who are part of the ongoing action that deals with the direct experience of people in specific contexts (Orb, Eisenhauer & Wynaden 2001). This paradigm rests on the assumption that human beings are subjects of their own history and context who produce meaningful accounts of the world. Therefore it is important for us to know what these individuals experience and how they interpret the world (Cohen 1981).

The aim of this research was to understand the social and contextual influences of clinical placement that may influence student nurses' ability to bridge the theory to practice gap to enable the provision of PCC. A Critical social theory approach according to O'Loughlin (1992) works to bridge the theory to practice gap through reflection on practice. Critical social theory has been described as a useful theoretical framework to observe and critique the existing conditions of the workplace. This critical analysis can then be implemented to enhance the individual's autonomy and responsibility and through reflection, can liberate the individual from both conscious and unconscious constraints (Wilson-Thomas 1995).

Critical Social Theory was considered the most appropriate theoretical framework for this thesis as it encouraged the researcher to consider what conscious and unconscious constraints might be revealed for the students as participants in the clinical environment.

### **Historical and philosophical underpinnings**

Critical Social Theory originated with a group of Marxist orientated German scholars in the 1920's referred to as the 'Frankfurt School'. This was not a school in the physical sense, but rather a school of thought associated with some scholars at the Institute for Social Research and the University of Frankfurt in Germany. Under the leadership of Max Horkeimer, the distinguished critical theorists included Herbert Marcuse, Theodore Adorno, Friedrich Pollock, Erich Fromm, Franz Neumann and Leo Lowenthal. These scholars believed that no aspect of social phenomena can be comprehended unless conclusions are drawn from the historical and structural contexts in which it is situated (Stevens 1989).

The scholars of the Frankfurt School were concerned by the emerging forms of capitalism and the effect it had on the working class. They believed that the traditional Marxist theories required modification if they were to be relevant in the 20<sup>th</sup> century (Manias & Street 2000). The purpose of CST were to be able to challenge the traditional assumptions of truth, knowledge, and power through the development of a critical pathway for social change (Holter 1988; Stevens 1989).

## **Jürgen Habermas**

After World War II, many scholars moved to the United States and CST lost its momentum. However, in late 1960 Jürgen Habermas led a movement that rejuvenated the Marxist ideology in the Frankfurt tradition. Habermas (1971), believed that in order to free people from domination, social critique must be geared towards challenging the structures and ideologies of the social systems. He described critical theory as a means to generate knowledge based on free, un-coerced, undistorted communication. Habermas contends that there are three areas where cognitive knowledge is generated and he describes these as being technical, practical and emancipatory (Habermas 1971).

The first area where cognitive knowledge is generated is the technical orientation, which is associated with labour, where individuals learn to control the environment. The second cognitive orientation is the practical interest, which relates to the communication and interactive processes where language and communication maintain the structures of power that exists in relationships. The third orientation being the emancipatory interest, involves the development of self-knowledge and the gaining of power over forces that control one's life (Habermas 1971).

The emancipatory orientation is of particular interest in nursing education as it seeks to expose the power in relationships so that freedom can be sought from the social and ideological constraints that exist and the power relationships that can shape society. Habermas (1971), contends that critical analysis must occur because the constraints of power exist within the unreflected communication. It

is through radical reflection that one can attempt to examine habits, rules and traditions that are accepted without question.

Habermas (1971) Theories of socialisation, vulnerability and considerateness have a particular applicability for professional caring in nursing because of the unique patient nurse relationship where both parties are vulnerable. On one hand the role and expectation of the nurse is that they will demonstrate caring, empathy, knowledge and skill regardless of the fast-paced understaffed environment, which can lead to a feeling of failure and frustration on the part of the nurse (Sumner & Danielson 2007). In addition to this, the patient expects to be considered, that their complex needs, and feelings are met. If these expectations are not met, then the patient may complain that the nurse does not care. In this context, CST can facilitate the nurse to reflect on the quality of care they are delivering and to question the conflict that can arise when attempting to meet the patient's needs whilst adhering to the demands of the health care system.

### **Paulo Freire**

Paulo Freire was a Brazilian educator and philosopher who was a leading advocate of critical pedagogy. Freire is known for his work the 'Pedagogy of the Oppressed' which is considered to be the most influential and foundational text of the critical pedagogy movement. Freire (2000) believed in liberation through reflection and action, which enabled the transformation of oppressive conditions. CST forms the basis to this approach and is underpinned by the

philosophy that social phenomena are understood in contextual and historical terms (Mooney & Nolan 2006).

Freire contends that praxis is the key to liberation and this stems from the development of self-awareness and knowledge, which then results in power over forces of control. He proposes that effective education will create students who challenge problems and discover solutions but this can only be achieved if the education is contextual and relevant to those to whom it is directed (Freire 2000). Wilson-Thomas (1995) supports this idea and suggests that CST is useful in creating autonomous students who are responsible for their actions and accountable and ethical in their practice.

Freire's philosophy is important for nursing and relevant in the examination of how student nurses engage and adapt to the clinical environment when considering a PCC approach to nursing practice. Critical thinking abilities are important when students are being prepared to function in a rapidly changing health care environment (Ironsides 2003). Critical theory can be used to critique the ideological underpinnings of nursing science in order to overcome the prejudices and constraints of power that have existed in nursing in the past (Browne 2001). In nursing education, CST can be associated with supporting self-awareness and reflection, leading to professional development and growth. It is therefore important that nursing students have an understanding of the wider context within which nursing exists from a CST perspective, as this will enable them to continue to develop strategies to manage their work environment and advocate for improvements in patient care (Wilson-Thomas 1995).



## **Critical Social Theory, nursing education and practice**

These early theories are important to nursing researchers when seeking to reconstruct the power relations in nursing. The utilisation of CST can raise the consciousness of an oppressed group and can explain why people are dissatisfied with their work. This process of critical thought and enactment can enable individuals to develop alternate ways of understanding themselves and their social context (Fay 1987).

Several nursing scholars support CST as a means to probe the complexities of discourse and the social world of professional nursing (Bent 1993; Holmes & Warelow 1997; Holter 1988; Porter 1994; Ray 1999). The reason for this is that nursing practice occurs within a social relationship and focuses on the human response to illness. CST offers a means to question power relationships and allows the examination of the nurses needs within the relationship. Sumner and Danielson (2007) suggest that CST is a useful means of exploring caring in nursing, to enable the questioning of practices that are taken for granted and to challenge the practices that work and those that do not. A meta-study conducted by Rundqvist and Lindström (2005) found there was a lack of mutuality in the nurse patient relationship. They found that the inherent power that exists in this relationship meant that the nurse will have the overall responsibility for the patient and the patient is unable to change this (Rundqvist & Lindström 2005).

Applying CST to nursing practice enables the researcher to gain an increased understanding of the subjective 'lived experience' of the student nurse within

the social systems in which they study and practice nursing. The purpose of CST in this context is that it enables the identification of those factors that reduce the individual's vulnerability and therefor facilitate their emancipation. Benner et al. (2009) questions the present health delivery system and its distortion of traditional norms of nursing, she believes that this leads to frustration and a sense of failure and fulfilment as a nurse. They also question the reality for the patient where there is a sense of being uncared for and a lack of spiritual nurturance even though they acknowledge the nurses' technical ability. A CST approach enables the exploration of the historical assumptions of professional nursing and the influence they have on nursing practice today (Sumner & Danielson 2007).

## **Summary**

This chapter has sought to describe the research methodology chosen for this study and the use of critical social theory in the exploration of the student nurse experience of clinical practice. In particular, the study has explored how the socialisation of the clinical placement environment affects their ability to deliver PCC. Historical and philosophical underpinnings of critical social theory have been studied from the perspectives of scholars such as Jürgen Habermas and Paulo Freire. The use of critical social theory has provided means to analyse nursing values and practice and has assisted in understanding the historical roles that have been expected of the patient and nurse. CST enables critical reflection and questioning of current nursing practice and assists in the reflection on how this effects the delivery of PCC.

The following chapter describes the qualitative research methods utilised to collect the data for this research project. The research design will also be described where a two stage approach was taken being Stage one where a curriculum mapping process was conducted and Stage two which was to conduct focus group discussions with the nursing students

## Chapter 4

### Methods

#### *Introduction*

This chapter will provide a detailed outline of the method used for this research. This includes ethical considerations. In this chapter, I have outlined the methodological approach taken for this research project. Beginning with the design, the recruitment strategy used, and the issues of anonymity, ethics and data storage have been discussed. An outline of the two-stage approach to this study has been provided.

#### **Research Design**

A qualitative research design, framed within a critical social theory paradigm, was used to understand the influence of clinical experience on the nursing students' understanding of patient centered care

The research design incorporated two stages:

Stage one - A curriculum mapping process

Stage two - Focus group discussions with nursing students

#### **Ethical Considerations**

This study was approved by the University of Adelaide Human research ethics committee number (Appendix 1, Approval No: 2014-224) Qualitative research focuses on the exploration, examination and descriptions of people in their natural environments. The purpose of such a study is to describe a phenomenon through interviews and observations to present the participants

point of view. In the interpretation the researcher recognises that participants are autonomous and willing to share information (Orb, Eisenhauer & Wynaden 2001). By accepting these statements, researchers recognise that the sharing of information encourages disclosure, and therefore it is important to maintain trust and to be aware of any potential ethical issues.

When deciding to conduct the focus group discussions it was important that any possible outcomes were considered and that the benefits and potential harm was examined. Ethical dilemmas that arise from an interview can be unpredictable but the researcher must be vigilant of any sensitive issues or conflicts of interest that may arise.

The standards of ethical conduct in research are based on three broad principles, which are that of beneficence, respect for human dignity and justice (Saks & Allsop 2007). Beneficence requires the researcher to minimise harm and to maximise the benefits. Adherence to the rights and safety of all participants was of paramount importance throughout this study and the values and principles outlined in the “National Statement on Ethical Conduct in Human Research” (National Health Medical Research Council, Australian Research Council & Universities Australia 2015).

The right to be informed is a principle that has been honoured for this research study and thus informed consent has been obtained. This also means that the participants were autonomous volunteers with the right to accept or refuse to take part in the study. In the early stages of this research, an information flyer via the University student email system was distributed to all 3<sup>rd</sup> year student

nurses inviting them to participate in this study (Appendix 2). The students were informed that they could register their interest by their student email and any clarification about the nature of this research could be given at this time (Appendix 3). Consent was obtained prior to the commencement of the discussions (Appendix 4). The students were informed that if at any time they found the discussions stressful or upsetting the discussions would be ceased and the needs of the individual would be assessed. They were also informed that if an issue arose that required any ongoing counselling the appropriate student counselling resources would be provided (National Health Medical Research Council, Australian Research Council & Universities Australia 2015).

The principal research coordinator Dr Lynette Cusack's contact details were provided to all participants in the unlikely event of any adverse outcomes. Had this occurred details of this event would have been identified and the level of potential reoccurrence assessed. Any adverse outcomes would have been reported directly to the Human Research Ethics Committees HREC (University of Adelaide) (Appendix 1).

It is important to note that at the time of data collection the researcher did not have a current teaching relationship with the participants. The researcher did however have a prior teaching experience with the students. Students were informed that this prior relationship would have no bearing on what was shared or their progress in the Bachelor of Nursing program. Students were reminded about their ability to withdraw from the study at any time. Anonymity was assured with written transcripts available for validation from the participants.

The written transcripts were provided to the participants for approval and to check for accuracy.

### **Anonymity**

The researcher ensured privacy of all participants' personal data by storing it on a personal drive of the University of Adelaide's computer server that is only accessible to the researcher. Data was de-identified and the names were replaced with codes before any analysis was conducted or data transcribed, only the coordinator had access to the names for the purposes of validating transcripts. Names were not used during the recorded sections of the interviews. Confidentiality was also maintained by guaranteeing that no participants were identified in any of the data.

### **Storage of data**

All data has been stored on the University of Adelaide server under conditions identified in the Australian Code for the Responsible Conduct of Research (2015).

### **The Setting**

The subjects for this research were year three student nurses currently studying the Bachelor of Nursing at the University of Adelaide. The program offered to these students has been accredited by the Australian Nursing & Midwifery Accreditation Council (ANMAC) and is based on a theory to practice model where students gain extensive practical experience in the clinical setting. The bachelor program is structured over an extended academic year to facilitate

and increase the amount of clinical time available to students. As a result, these students were in an ideal position to contribute in a meaningful way about their experiences in the clinical environment.

## Stage 1

### Curriculum map

#### *Mapping the big picture*

The first stage of this research was to conduct a Curriculum mapping exercise identifying the terminology used within the existing curriculum that supported a nursing model of patient centered care. The curriculum was mapped across the 24 courses of the Bachelor of Nursing program at the University of Adelaide.

The curriculum-mapping model was based on the work of an internationally recognized education leader Jacobs (1997) whose expertise is in curriculum mapping, curriculum integration and development approaches to learning and teaching. Jacobs (1997) work addresses the necessity to synthesise various education models and create a framework that focuses on the recommendations, requisites and desires that effect students learning and teaching environments.

#### *The importance of curriculum mapping in higher education*

In Universities where major fields of study encompass a collection of courses there exists the opportunity to design a coherent curriculum. The curriculum need not follow the traditional sequential model but might choose a problem



based or issue based format where students are able to make ever-deepening inquiries into concepts and principles. Schools within the universities are therefore in a position that enables students to broaden and deepen their understandings by crafting a series of courses that are carefully orchestrated to advance the essential knowledge and skills in fields of study. (Burnard 1991). When designing nursing curriculum, it is also important to comply with the regulation bodies' accreditation and practice (competency) standards.

One aim of curriculum mapping is to identify the content taught in each course at each level. This can help highlight gaps in what is taught and reduce any repetition that may exist among courses. It allows for integration of content to enlarge the students understanding of central concepts (Burnard 1991). Curriculum mapping provided the foundations, which enabled the formulation of a hypothesis based on how and when the students are exposed to the theoretical components of PCC. The hypothesis being that student nurses are influenced by both the curriculum, the language used to teach PCC and the socialisation that occurs in the clinical environment.

## Stage 2

### **The Participants**

The subjects for this research were third year student nurses who have experienced nursing practice in a range of clinical placements. All students were invited to participate from a cohort of 179 students. It was decided that anticipated number for the three focus groups would not exceed 12 as this was deemed by the researcher and in consultation with the supervisors to be an

acceptable number to generate lively discussion but not too large to manage in a focus group.

## **Sampling**

Purposive sampling was employed as the most useful way to select the individuals required for this qualitative research. Purposive sampling is designed to develop theories and concepts and to enhance understandings of selected individuals or group's experiences. To do this the researcher must select information rich cases that provide the greatest insight into the research question (Devers & Frankel 2000). Patton (1990) has identified more than a dozen strategies for purposive sampling. Of these, the strategy most suitable to meet the conceptual and substantive needs of this research was "Maximum Variation Sampling." This strategy is the most widely used method of purposive sampling. This involves selecting persons with a wide range of interests or settings. Although the student nurses were enrolled in the same degree, the nature of their clinical placement was varied, not only by location and specialty but also by their own experiences. One of the major advantages of maximum variation sampling is that common patterns can emerge and are of great value in capturing core experiences (Polit & Beck 2008).

## **Focus Groups**

A qualitative research methodology was chosen for this study based on the understanding that the social world can only be understood from the standpoint of the individuals who have direct experience in a given context (Orb, Eisenhauer & Wynaden 2001). This methodology is based on the assumption

that human beings are part of their own history and give meaningful accounts of their world (Orb, Eisenhauer & Wynaden 2001).

Focus groups have been a popular method to generate data since 1980 and have a long history in social research. Focus groups are a useful way to seek the views of a community where the participants can frame their own concerns in their own terms rather than that of the researcher. They allow for analysis of the discussion rather than single opinions and allow the complexity of views to be studied (Saks & Allsop 2007).

Cohen, Manion and Morrison (2013) describe four kinds of interviews that may be used specifically as research tools, which can be applied to focus groups. *Structured interviews* are where the content and procedures are organised in advance and the sequence and wording of the questions are determined by a schedule. In this instance, the interviewer is left little freedom to make any modifications. *Unstructured interviews* constitute an open situation where the wording, content and sequence are in the hands of the interviewer. The *non-directive interview* derives from the therapeutic or psychiatric interview. Minimal direction is exhibited and the respondents have a considerable degree of freedom to express their subjective feelings. A degree of compromise to give some greater focus to the participant while still enabling the researcher to explore deeper issues is represented by the *semi-structured interviews* where the meaning of the described phenomena is obtained from the descriptions the interviewee gives of his world (Kvale & Brinkmann 2009).

Focus groups utilising semi-structured interviews were thought to be the most appropriate research method for this study as this enabled the researcher to analyse the ideologies that existed for the student nurses about nursing education, learning, practice and human caring. In addition, the potential for discussion in focus groups meant that broader views could be raised and investigated such as; what the students know how they know it and how this knowledge is communicated in social interaction.

Although the questions used in the semi-structured interviews with the student nurses were relatively organised (Appendix 5), the interviews remained open ended in the sense that they permitted respondents to describe what was meaningful and salient to them without being pigeonholed into categories (Patton 1990). As the interviewer it was my task to make it possible for the interviewees to bring me into their world and to help me understand as much as possible from their experience and point of view (Patton 1990).

### **Recruitment Strategies**

Prior to the recruitment phase a flyer promoting the study was distributed to all third year nursing students via MyUni (The university communication interface). It was decided that it would be ideal to recruit at least 25 students for this study so a strategy was formulated to maximise the information available to them. Having distributed the flyer, the researcher then held a face-to-face presentation in class, which explained the research topic, and its purpose. At this time, an information sheet was distributed to the students asking for volunteers for the focus group discussions. To engage their interest and to give

meaning to their participation in this research project it was important to explain that the researcher was interested in their experiences of delivering PCC whilst on clinical placement and particularly interested in the strategies they employed that enabled them to deliver PCC in any given context. It was explained that the discussions required no previous reading or specific knowledge of PCC and that although the discussions were to be recorded the sessions were to be relaxed and informal. Focus group schedules were then distributed to encourage participants to book in advance into one of the focus group sessions.

### **Data Collection**

The purpose of informing the students prior to the focus group meetings with the Participant information sheet allowed them time to reflect on the content without becoming too focused on giving answers to specific questions. The period allowed for each focus group interview was relatively short, approximately sixty minutes; this meant that by having the participants well prepared they were less likely to “ramble” unnecessarily. Measor (1985) suggests, however, that in an interview rambling can be important and worthy of investigation but in yielding some degree of control to the participant the payoff can be that the researcher reaches the data that is central to the subject (Measor 1985).

The quality of data gained in an interview is often dependent on the quality of the relationship built between the respondents and the interviewer. Seidman (2013) argues, however, that too much or too little rapport can lead to distortion of what the participants contribute in the interview. It is therefore important for

the interviewer to maintain a balance between respecting what is being said by the participant and taking advantage of the opportunities to ask the difficult question and to engage more deeply in the controversial issues (Seidman 2013).

Interestingly the questions did not follow a set order but I was able to cover the areas that I had intended without having to impose a rigid line of questioning onto the interviewees. The topic developed freely according to the nuances of each discussion group without needing my constant direction. Throughout each interview, I was aware of my own preconceptions, values and beliefs and made note of how these might interrelate with the interviewee's responses. My thoughts and observations were recorded in a personal journal, along with observations of the participants' body language and emotional reactions. These then formed the beginnings of the more structured reflection and analysis that was to take place at a later stage.

## **Summary**

In this chapter, I have outlined the methodological approach taken for this research project. Beginning with the design, the recruitment strategy used, and the issues of anonymity, ethics and data storage have been discussed. An outline of the two-stage approach to this study has been provided. The following chapter will explain how the thematic analysis of the transcribed interviews was conducted utilising a critical social theory perspective.

## Chapter 5

### Data Analysis

#### Introduction

The focus group interviews conducted for this study were straightforward and the data gathered was extensive. A thematic analysis approach by Burnard (1991) was chosen, as it is a flexible and useful research tool, which helped to provide a rich, detailed and complex critical account of the collected data. Underpinning this process was the curriculum mapping exercise which identified the content taught in each course in each year level. This process provided the foundations, which enabled the formulation of a hypothesis based on how and when the students are exposed to the theoretical components of PCC. The hypothesis being that student nurses are influenced by both the curriculum, the language used to teach PCC and the socialisation that occurs in the clinical environment. This was important to keep in mind when analysing the data.

#### Thematic analysis

Analysis of data is commonly described as either deductive or inductive in its orientation. Deductive analysis requires a hypothesis and specification of variables before data collection begins. The important variables and relationships that may exist are decided in advance and data is then collected and analysed according to the hypotheses (Patton 1990). Conversely, inductive analysis makes sense of the situation under study without imposing any pre-existing expectations on the phenomenon being researched. Inductive analysis

requires the researcher to immerse themselves in the details of the data and to discover the interrelationships and important categories and dimensions (Patton 1990).

As the researcher comes to understand patterns of the world under study categories of analysis begin to emerge from the open-ended observations. These important dimensions of analysis can then begin to emerge without having any preconceptions of what these may be (Patton 1990). My interest was in making sense of the situations under study without having any pre-existing expectations therefore the qualitative methods used in this study were particularly oriented toward an inductive process.

The aim of the research analysis was to produce a detailed and systematic recording of the themes that emerged from the focus groups in a relatively exhaustive category system. To do this I utilised the stages of analysis as described by Burnard (1991), using an open coding system to find common themes throughout the transcripts. This process of open coding was adapted by Burnard from the grounded theory literature by Glaser and Strauss (2009).

### **Stages of the analysis**

Burnard (1991) suggests 14 stages to the analysis of qualitative data such as a transcript however, for the purpose of the research study I have adapted this method further to only include 10 stages. Each stage and the way in which the stages have informed the analysis process are explained below. The rationale was that some of Burnard stages, such as the exclusion of dross were not used as it was important to focus the analysis as tightly as possible. I did not engage



additional respondents to check the appropriateness of my category system, as is suggested by Burnard (1991). Guidance with reviewing the transcript data and the thematic analysis has occurred in consultation with my supervisors. Copies of the transcripts were sent to all participants for review and although the responses were de-identified, they all agreed that the data was an accurate transcription of the discussion.

### *Stage one*

This stage requires the researcher to take notes during or after each interview. These notes record anything of particular interest throughout the discussions. In the first focus group, I facilitated the focus group questions and the recordings and enlisted the aid of a colleague, who took notes of important points as the discussion progressed. In the subsequent focus group discussions, I found that I had more success when recording notes immediately after in a journal. These notes were useful later on as they recorded some themes that were already emerging.

### *Stage two*

Once the focus group discussions were completed the audio recording of each focus group were transcribed verbatim and returned for reading. In the first instance, I found it useful to listen to the recordings several times and make notes, paying particular attention to what 'lay beneath' the spoken word. Listening to the student's tone, enthusiasm and passion added to the authenticity and sincerity of what they were saying. Once this process was complete, I then focused on the written transcripts with the aim of becoming

'immersed' in the data as an attempt to become fully aware of the 'life world' of the respondent.

### *Stage three*

Having worked through the recordings and transcripts many times the next stage was to highlight particular comments, or quotes that were relevant throughout the discussion. These quotes were then cut out and pasted onto butchers' paper, which was posted on a wall in a private location to more easily observe for patterns or themes that were evident for each group. These comments were colour coded to coincide with the questions that had been asked during the focus group discussions. The headings used were directly related to the objectives of the study. This system is known as 'open coding' according to Bruce and Berg (2001) where categories can be freely generated.

### *Stage 4*

The comments were transferred using Excel as this facilitated the easy movement of themes and sub themes. Three main categories were used, which related to the study objective. 'How students reflect on PCC' the 'Impact of PCC' and the 'Strategies used to provide PCC. From the main categories I then developed the sub themes and from these key words emerged which summarised the underlying nature of what the students were describing.

### *Stage 5*

This stage required a new list of categories and sub-headings are worked through. The approach used was to refine my theses on several excel

spreadsheets redefining the data each time. Some comments required more than one sub theme as I attempted to narrow the focus on the true meaning of what the students were trying to say. Key words were used to highlight for me the significant points that were being made. This process was useful as it enabled me to identify each of the sub-headings into a specific category of comments.

### *Stage 6*

This stage describes a process where two colleagues are invited to generate independent category systems without seeing the researchers list of codes. I was unable to do this however, I did work with my supervisor to firstly categorise some of the comments. Once this was underway I sought feedback on my interpretations of the data that were emerging from the open coding process, my supervisors provided this feedback.

### *Stage 7*

Prior to commencing the interpretation chapter, I listened to all recordings again and re-read the transcripts so that the information was fresh in my mind when I began. All the excel spread sheets were available as were the full transcript copies. This allowed me to move from the comments and themes I had developed back to the transcripts to maintain the contexts of what the students were describing. This also added to the validity of the analysis.

### *Stage 8*

This stage presented the data with an interpretation or summary of what was being said. Working through each section of the data, I added a commentary that explained or described the intention of the student's words.

It was important during this stage to use examples that accurately reflected the commentary. During this time, I continually referred to the transcripts and recordings to keep as close as I could to the original meanings and contexts.

### *Stage 9*

Here I needed to decide whether to link the data examples and commentary to the literature. Burnard (1991) suggests two options that are available. Firstly, the researcher may use verbatim examples of the interviews followed by a link to those findings in the literature and make comparisons and contrasts. Secondly, the researcher can choose to write the findings with references to the literature adjacent to these. I have chosen to link the comments to the literature in the discussion chapter below.

### *Stage 10*

According to Burnard (1991) there are always elements of interviews that are unusable when presenting any data. Recognising what is relevant to the research, what can be omitted was difficult, and my desire was to include all noteworthy comments. Trying to identify which of these were the most relevant and pertinent to the research question meant that some examples had to be excluded. Morse and Field (1995) refer to unusable data as 'dross' meaning data that does not really convey anything.

## *Reliability and Validity*

The issue of validity was considered, as the researchers aim was to offer a glimpse of another person's perceptual world (Burnard 1991). With this in mind, it was important that any bias on my part was removed and that subjectivity did not creep through. In qualitative research the richness of data collected through semi structured interviews bolsters validity and because the data is so detailed it also guards against bias (Saks & Allsop 2012). The intention of the non-directive nature of the open-ended questions was to enhance the validity as the participants could articulate their experiences rather than having to conform to any predetermined answer categories.

Krueger and Casey (2009) suggest that the credibility of focus groups is high because the data that emerges is very believable. This paradigm relies on Habermas's (1971) belief of the validity of human speech where credibility is built into the study framework. The interviews in this study were recorded and transcribed verbatim by an independent transcriber who had considerable experience in transcription. Extensive notes were taken at the end of each interview and referred to when reflecting on the comments made in the transcriptions. The transcriptions were sent to all participants for review. This also contributes to the reliability and trustworthiness of the data collected as it affords the opportunity for the participants to validate or dispute what was said in the focus group discussions. There were no disputes raised with any of the students after reviewing these transcripts.

## *Summary*

This chapter has outlined the 10 stages utilised in the analysis of the qualitative data collected from the focus group interviews for this study. Using inductive reasoning and an open coding system, the researcher was able to produce a detailed and systematic recording of the themes that emerged from the focus groups under study. Common themes emerged during this process, which are explored more fully, in the following chapter where I will seek to interpret the themes and give meaning to the student nurse experience as their ability to understand a PCC approach to nursing.

## Chapter 6

### Interpretation

#### Introduction

This chapter presents the analysed data collected from the focus group interviews. The data has emerged as a result of the Curriculum mapping exercise, (Stage 1) and the thematic analysis of the transcribed focus group discussions as outlined by Burnard (1991) (Stage 2).

This research explored the student nurse experience and sought to answer the research question:

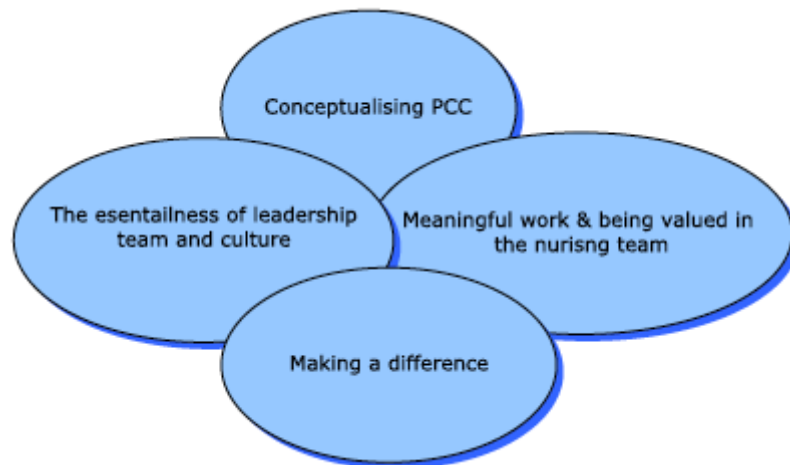
*“What is the influence of clinical experience on the nursing student’s understanding of patient centred care?”*

The interview questions were directed around the key themes that were identified in the literature review and were centred on student knowledge, practice and reflection.

Several themes have been identified from the focus group interviews which have provided a rich commentary on the student nurse experience and knowledge at a third year level. This commentary is important as it reflects the ability of this group of student nurses to not only clearly articulate the knowledge gained throughout their university course but to reflect and interpret how this knowledge translates to their ability to understand and provide a patient centred care approach. From the focus group themes four main themes emerged from the analysis, (see figure 1) Conceptualising PCC, the essentialness of

leadership and culture, 'meaningful work' and 'being valued in the nursing team' and 'making a difference'.

*Figure 1 Conceptualising PCC*



### **Conceptualising Patient Centred Care**

The opening questions were directed towards the students understanding of the term, Patient Centred Care and how they recognised this on clinical placement. When asked what the students knew about PCC and where they had heard the term before they described that whilst they had not attended any classes directly focused on a patient centered approach to care they said that this theory had been implied in many first year classes.

*“First year Uni, all of our first year lectures.” (Student FG3, Pg. 1)*

*“Reinforced a lot at Uni” (Student FG2, Pg. 1)*

The inherent implication of PCC in these early lectures and their clinical placement experiences so far had provided them with a very clear view of how



this care should look in practice. They were asked how they recognised a patient centred approach to care;

*“I feel like it’s working with the patient to achieve an outcome so it’s not you enforcing the rules..... I think it’s working with them to suit their personal needs to make an outcome successful.” (Student FG. 3, Pg. 1)*

*“To include the patient in their care and not talk over them.” (Student FG 1. Pg. 1)*

The students also described that they believed the relationship between the nurse and the patient was central to a patient centred approach to care. They believed that the care should be personalised so that trust could be established between the nurse and the patient.

*“You build a relationship” (Student FG2, Pg.1&2)*

*“Making sure they feel safe” (Student FG1, Pg.1)*

To have a mutual understanding of goals was important and that including patients in handover discussions enhanced this.

*“Encourage patients to talk and to interact in handover, give them permission to communicate their needs.” (Students FG2, Pg. 5)*

All participants expressed the desire to “care” for patients and clearly understood the complex nature of this concept. They recognised that this was an important issue for both nurses and patients.

*“Making sure that what you’re going to do is in their best interest according to them.” (Student FG3, Pg. 1)*

## **The essentialness of leadership, team and culture**

These student nurses found that the ability to provide care was a very satisfying experience and that this enhanced their self-esteem as a student nurse and made them feel a greater sense of belonging to the nursing team.

*“I think when staff are rewarded...it’s acknowledged that they do a good job that makes a difference to the culture. A good CSC and a good ward environment.... makes a big difference to the way they deliver their care.” (Student FG. 1, Pg.4)*

When asked where they had seen patient centred care in practice all three groups of students agreed that the nurses who worked in Mental Health venues were more patient centred in their approach. They observed that this focus on the psychosocial aspects of the patient seemed more patient centred as it relied on greater communication with the client.

*“In mental health it’s where they do the patient centered care.” (Student FG 1. Pg. 2)*

*“I saw a lot of empathy when I was at mental health [mental health placement] they have more time to work with a person’s needs and their desires about how they want to manage their own health, they are much more open to empowering them.” (Student FG 3, Pg. 2)*

In comparing this experience with an acute care setting they felt that the focus was often more on the illness or intervention and therefore not holistic in their intention. They also recognised that this is not a constant, that individual wards

within large hospitals can have a greater focus on PCC than others, and that this was dependent on the quality of leadership and the cultural expectation of that ward or health care provider.

*“I have found that the approach to care depends on the culture and expectation set up on that particular ward. So wards can vary in any one hospital” (Student FG 3, Pg. 2)*

*“Acute settings are more about illness as opposed to the person” (Student FG 4, Pg. 3)*

Of particular interest was the impact the clinical placement environment had on the student’s ability to provide PCC. When reflecting on the cultural values that they encountered on many placements they believed that patient centred care was practiced when there was a cultural expectation to do so. Wards or venues they noted that supported staff to be patient centred and not solely task driven were beneficial to both staff and patients.

*“A big part of why PCC is not practiced is the culture of the ward. I think if the CSC is a person who really focuses on PCC, it might not be a written policy, but they have an understanding that this is what nurses should provide then that makes a lot of difference.”*

*(Student FG 1, Pg. 4)*

*“A good CSC and a good ward culture with a team who get along with nurses who are acknowledged for their good work can make a difference to the way they deliver their care.” (Student FG 1, Pg. 2)*

They compared this experience with a student nurse exchange in which they took part that occurred with Japan earlier in the year. Here they witnessed respectful nursing care delivered to patients who also expected a certain way of being treated. This they noted was a cultural expectation where no one was too busy or tried to provide “good care”.

*“In Japan respectful behaviour is expected and therefor received.”*

*“Everyone talks quietly and politely.”*

*“The culture of the Japanese expects a certain standard and way of being treated without demanding it.” (Student FG 3, Pg. 12)*

This experience highlighted for them that PCC enhanced the patient experience leading to greater confidence in the nursing staff, and less anxiety in the patients.

*“Being patient centred makes a difference to the patient because their perception of care is enhanced.” (Student FG 3, Pg. 13)*

*“PCC builds confidence and relieves anxiety.” (Student FG 3, Pg. 14)*

*“Spending time with the patients enables the therapeutic relationship to develop.” (Student FG 3, Pg. 14)*

## **Meaningful work and being valued in the nursing team**

Many students gave examples of less than optimum patient centered care, which were especially prevalent in reference to residential care facilities. They were asked to consider why they thought this occurred. They described the care to be routine driven, within a very tight schedule, leaving no time or incentive to be patient centred. Inadequate staffing and resources, they felt, had a negative impact on the care that could be provided.

*“I remember most days we’d be still doing ADL’s up to lunch time and people were still getting fed at like 1pm to 2pm in the afternoon because we were so behind, and it was like just get more staff, these people deserve better.” (Student FG 2, Pg. 9)*

One student described the conflict that she observed for many nurses where they were torn between fulfilling the role of the nurse as carer whilst adhering to strict timeframes with poor resources i.e.; poor numbers of adequately trained staff and inadequate supplies. The students expressed that these issues influenced how they themselves, experienced nursing and that working in these environments contributed to their disenchantment with aged care nursing.

*“It can be influenced by the establishment’s criteria, when I was at aged care they have so many people that they have to get through in that shift and that’s what is expected from that shift, so then you’ve got the nurse deliberating whether she stays there with the upset resident or sticks to the schedule to get things done. That’s a really conflicting issue; the*

*need to fulfil your role versus the establishments needs to stick to their budget” (Student FG 1, Pg. 2)*

The students from Focus Group 3 expressed frustration that time and tasks would often interfere with PCC, conversely the students saw themselves as having that time when the registered nurses often did not. This was important to the students as they felt they had an important role to play.

*“They were [the nurse] in and out in 30 seconds”*

*“They [the nurse] have to get things done”*

*“They [the nurse] want to do it they [the nurse] just don’t have the time”*

*(Student FG 2, Pg. 3)*

These students saw themselves as an additional workforce to be harnessed by the nurses; however, they are not included in the staffing numbers and often not seen as contributing to the running of the ward. This can have both positive and negative impact on the students as whilst they are able to negotiate spending more time with patients, attending to details and have meaningful patient interactions this can also result in the students feeling unappreciated for the part they are playing in the team.

*“Sometimes I don’t think they always see the best of us”*

*“You’re not allowing us to show you what we’re going to make of ourselves as nurses and how were going to come across to the patient if you’re compounding us with ‘get this done, make sure you do this.’*

*(Student FG 1. Pg. 2)*

## **Making a difference**

Towards the end of each of the three focus group interviews, the discussion was directed at gaining an understanding of the strategies the students used to enable them to understand and provide PCC in any given context. The participants were asked how they might overcome some of the difficulties they have faced as students when attempting to provide PCC. Interestingly they were mostly positive and expressed that overall they did not feel that providing good care was onerous in any way.

One strategy that was mentioned by many students was to seek their own information, not to rely on hearsay or a poor handover. While they acknowledged the importance of accurate patient notes, they also recognised the importance of engaging with the patient to make their own assessment.

*“It’s important to make your own assessment of the patient and not just read it from the nursing notes.” (Student FG 1, Pg. 2)*

The students were aware that building a picture and getting to know the patient and respecting their wishes achieved a better outcome and less resistance from the patients. This approach can lead to greater job satisfaction for the student nurse. They were of the opinion that PCC can be practiced anywhere any time you just need to talk to the patient while carrying out a task, negotiate a timeframe and include the patient in the decision process.

*“It’s not always about time, you can spend 5min or 25min and if you interact and develop two-way communication you can still give quality care.” (Student FG 2, Pg. 10)*

This they said is often met with opposition from senior staff who want all care to fit in within a designated period which can lead to increased anxiety in the nurse as they have to convince the patient to conform to this time frame leaving little opportunity for negotiation or personal preference.

*“PCC can be practiced anywhere any time you just need to talk to the patient while carrying out a task.” (Student FG 2, Pg. 10)*

Of particular interest was how they managed the time constraints and demands of other patients and how they involved the family members.

*“It’s important to work around the patient, showers do not have to be done by 10am, while doing tasks you can be chatting to the patient and this enhances PCC.” (Student FG 1, Pg. 10)*

*“At the beginning of each day I go and talk to all my patients and tell them what we are going to do for the day.” (Student FG 3, Pg. 14)*

*“Involve the family and find better ways to communicate” (Student FG 3 Pg. 2)*

*“Help the family to understand what the patient needs” (Student FG 1, Pg. 3)*

Team STEPPS was discussed often in the interviews by many students who see this as a positive way to work in a team and in the best interest of the patients. Team STEPPS is an evidence-based teamwork system, which has been introduced into South Australian hospitals as a strategy aimed at optimizing patient care by improving communication and teamwork skills. Four



key competencies are the focus of this strategy, which are leadership, situation monitoring, mutual support and communication. The students who had worked in areas that embraced this teamwork strategy explained that it created a sense of order and support for the nursing staff. They observed that where wards held regular “huddles” [Part of the Team STEPPS strategy, which are standing, informal meetings, held in hallways] that teamwork was enhanced and this practice helped staff to talk about their patients and their workload.

*“Regular team meetings help staff to talk about their workload.” (Student FG 2, Pg. 3)*

Students see team huddles as informing and reassuring, helping them to feel part of the team where they can talk about their patients and seek help or advice.

*“Huddles help to prioritise workloads.” (Student FG 2, Pg. 3)*

These meetings promoted inclusion and validated the part the students were playing in the care of the patients.

*“Feeling empowered myself helps me to perform good PCC.”  
(Student FG 2, Pg. 3)*

The students agreed that many tasks could be modified and that an assessment can be made whilst talking to the patient. The students in this study did not see this as difficult but they observed that this was rarely seen in practice. Often nurses are observed to talk to each other even when attending to a patient; this is especially prevalent in the buddy system. The nurse often

forgets to include the patient in their conversation. The buddy system according to the students only works when both nurses are focused on the patient.

*“Buddy nursing can either detract or enhance PCC.”*

*(Student FG2, Pg. 4)*

A suggestion made was that nursing notes could be done at the bedside, which would enhance patient safety and inclusion and might lessen the anxiety of meeting deadlines for the nurse.

*“Nursing notes at the bedside works well for PCC.”*

*(Student FG2, Pg. 4)*

In all focus group discussions, the issue of the handover was an important topic. The students see this as a valuable time to gain important patient information to enable them to plan for the shift ahead.

*“The nurse I was with introduced herself to the patient and asked if they had anything to add to the handover.” Student FG1, Pg. 3)*

*“Encourage the patient to talk and to interrupt in handover, give them permission to communicate their needs.” (Student FG 2, Pg. 5)*

They also observed that this was rarely done well and often patients were not included in this process.

*“I have never heard a patient speak during handover.”*

*“There needs to be more work on how nurses interact with patients”*

*(Student FG2, Pg. 5)*

Some health care providers such as Mental Health and Paediatric specialties, they said, were good at the handover process, including the family and covering psychosocial issues in some depth.

*“There was a different kind of care when I was on “paeds” [Paediatric placement] ...it was very genuine and you could see it coming from the nurses, little things, asking them how they were, asking how the parents were as well.”*

In contrast to this, they thought that not all staff in acute care facilities were good at handover and that this varied from ward to ward depending on the cultural expectation of the staff that work there. Special mention was made about the large doctors' rounds often seen in the large government hospitals.

*“In ICU the doctors all came in as a big group and they literally discussed everything about the patient in front of them and said nothing to the patient and then when they left the patient said ‘what were they saying?’ I had to explain everything to her.”*

In comparison to the handover at the bedside, they explained that some private hospitals still use a taped handover; this means that the staff have already left for the day and so there is no opportunity to ask for clarification. They believed this to be a poor practice and not in the best interest of PCC.

*“At [private hospital named] they're still using quite an old method of sitting in the nursing tearoom and recording on a recorder and you just go through and then all of the other nurses come in and press play, there's no question answer opportunity, there's no face-to-face*

*interaction with the patient, there's no empowering of the patient to add to the story." (Student FG 2, Pg. 6)*

When the students were asked how they thought they might be able to sustain the patient centeredness that is important to them once they are registered nurses, they were mostly positive. They were hopeful that they would maintain the principles that have been taught in their studies and that the younger generation of nurses will contribute to changes in patient care. Flexibility and fitting routines around the patients seemed to be a priority.

*"I think there'll be days when the load will get to you and it will be pretty heavy but I think mostly you're going to strive for treating people how you'd like to be treated." (Student FG 3, Pg.13)*

*"I like to put patient's dressing gowns on or their pyjamas on or clothes on, if they're going to be sitting out of bed I like to put their clothes on, even if they're just going to be sitting in that chair for the day it's daytime, they're dressed, they want to sit out of bed, they want to watch TV, they might have visitors, they may not necessarily want their visitors coming and seeing them in a white hospital gown with no brushed teeth or no brushed hair." (Student FG 3, Pg. 12)*

## **Summary**

This chapter has highlighted the themes that have emerged from the focus group discussions and subsequent transcriptions. Four main themes have been highlighted from the focus group data, conceptualising PCC, the essentialness of leadership team and culture, meaningful work, being valued in the nursing

team and making a difference. These themes indicate that the participants have been exposed to some form of socialisation in the clinical environment and the effect this has on how they care for patients. This data reflects how these students have internalised the norms and values they have witnessed in the occupation of nursing and their ability to develop strategies to overcome some of the more negative aspects of the nursing culture.

In the next and final chapter, the themes are brought together to give voice and meaning to the student participants' valuable insights of their clinical placement experience and the influence this had on their ability to understand PCC.

## Chapter 7

### Discussion

#### Introduction

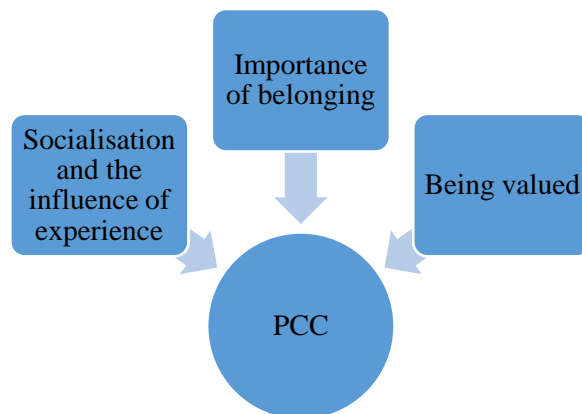
This chapter will consider how nursing curricula and PCC come together as a central theme when teaching student nurses the art of caring. The discussion will reconsider the contribution of Critical social theory, explore the influence of clinical experience; the nature of socialisation into the workplace and the importance that being valued and belonging has on the nursing student's understanding of PCC.

The analysis and themes have addressed the research question and revealed within this study and supports the original hypothesis that student nurses are influenced by the curriculum, the language used in the classroom and the socialisation that occurs in the clinical environment. What is evident is that the social and contextual influences of clinical placement on the capacity of nursing students to understand and to provide PCC are complex (See Fig 2). This complexity confirms previous findings (Sumner & Danielson 2007) that nursing care while directed (outwardly) to the human response to illness occurs (inwardly) within a web of discrete social relationships. Examining the nature of these social relationships through the insights of Freire's Critical Social Theory, reinforces the need for nurse educators to carefully examine the impact of the environment into which student nurses are placed. The introduction to clinical environs and the formative learning goals anticipated by educators must be made with an awareness of the clinical culture to which students are

exposed.

The discussion within will highlight how aspects of the clinical learning environment inform and shape the very manner in which students learn. The importance of this argument is to ensure that nurse educators are aware, engaged, critical and evaluative when considering the impact of placement on student development. While it might be controversial, an argument can be established that clinical venues should be audited not only for their specialty and potential to educate but also for their inherent social structures. The risk to students learning, professional development and own psychological health is an area of research that warrants further investigation. The risk to the nursing profession of poor student development is poor patient care.

*Figure 2 Themes essential to providing PCC*



### **Application of Critical social theory**

Critical social theory is the lens through which the complexities of the social world of clinical placement as experienced by the nursing students have been examined. Critical social theory informs our insights to power relationships

especially those that Freire (2000) describes as oppressive. This is an important concept to reflect on within this study, because an environment comprised of different professional individuals may unwittingly create an imbalance in power across those relationships. Whether by intentional design or the inevitable consequence of workplace politics there are exemplars of this imbalance, where student nurses are deprived of authentic, and well-constructed learning opportunities because of the imbalance in power relationships. This is further highlighted where students try to apply their knowledge and understanding of PPC as part of their development in their role as an emerging professional, do so in a setting that continually under-values their contribution to the team. Such a situation characterises how power relationships have the potential to become both oppressive and repressive.

In this context, true emancipation, as described by Freire (2000) is only achieved if the contribution of student nurses is valued and they are encouraged and supported to critically reflect and become aware of the social environment around them. Students also need an environment where they are able to step-up and take on their professional responsibility and accountability for the care they provide under the supportive supervision and guidance of a registered nurse. This highlights that the emancipation of nursing students to develop their agency as effective practitioners of quality nursing care is not only desirable but also necessary. Educators risk perpetuating the status quo of placements and experiences that far from emancipating simply extend 'how it has always been' and continue to facilitate the undervalued, subordinate role of nursing students within the health care team. There is much to gain from



empowering students and nurses as agents to meaningfully participate in the re-imagining of how clinical placements are constructively used in the profession of nursing. While the students in this study were provided the opportunity to reflect on the understanding and experience of PCC, it is openly acknowledged that the researcher has also achieved a deeper appreciation of how important the social world of the clinical placement is on their experience.

### **Exploring the influence of clinical experience**

The clinical placement experience is one of the fundamental tenets of any Universities undergraduate nursing program. The engagement with theoretical perspectives in the University setting alongside sustained practical experience in real world settings has a powerful effect on the development of the student. This structure constitutes a praxis model of learning, a model characterised by theory and practice in 'conversation' through a range of learning experiences.

Skills laboratories are also important adjuncts to the integration of theory and workplace. It is important that all three settings are understood, ideally they should be 'synchronous' with one another. Synchrony in this context means that they inform one another, that there are no stark differences in practice for example between lab and ward and that students have some capacity to move between each setting with consistency and confidence. The student insights to this where the themes of 'meaningful work' and 'making a difference' reflect students who can translate theory into the practice setting.

There is however a significant difference to note; students in theoretical and skills laboratories are often in controlled environments unlike the nature of clinical placement, which can have an unpredictable and chaotic element. The chaotic nature of a cardiac arrest for example may be overwhelming for some students however coupled with a clinical placement setting that is unsupportive it is likely that most students would feel displaced. While a cardiac arrest may be an extreme event it serves as a good example of how 'tuned' to the social structures around them students need to be.

### **Socialisation in the nursing workplace**

As noted previously, Olshansky (2007) argues that while caring is central to nursing it must be taught and modelled by passionate presentations, critical thinking, appreciative listening and constructive evaluation. The nursing workplace should ideally represent and reflect these values as it has a powerful and positive effect on the professional socialisation of students (Beck 2001; Diekelmann & Mikol 2003; McGregor 2005; Pullen Jr, Murray & McGee 2001). It is clear however that within the physical domain of the workplace, socialisation is a multifaceted concept where being valued, having a sense of belonging and having the opportunity to make a difference are equally powerful and positive influences.

Many students in the study described being valued within the workplace when they were seen to be busy and hardworking. The nature of this work however is not as transparent as one would think as senior nurses who often praise student nurses as hard workers and valuable members of the nursing team do

so simply because they observe students undertaking designated functional nursing tasks. Successful and valuable students who appear to be coping with the nursing tasks can lead to assumptions being made, by the nursing team that the students are proficient at what they are doing. Indeed, students who are regarded as valuable because of their ability to complete tasks may not be developing their deeper understanding or critical thinking about competent care as assessed by the nurses around them. Ironically, for students who do attempt to foster PCC, forging relationships and spending too much time engaging with patients has been interpreted as laziness (Yonge et al. 2002).

This tension between students wanting their contribution to be regarded as valuable and by default assigned task oriented work reinforces the different power relationships within the practice setting and unfortunately reduces the opportunity for deeper learning of PCC by the students. In essence, the dialogue between theory and practice about approaches such as PCC, so important for a student's professional growth, is not adequately enabled in the practice environment.

An assumption that busy-ness equals competence can often result in students being left to undertake functional tasks with little if any support from ward staff. This effectively removes the students from the social context where learning is as much a social process as it is cognitive. The loss of opportunities for students to converse and engage personally with colleagues and with patients is ironically a barrier to them having opportunities for the social inclusiveness critical to their professional development.

Being able to develop meaningful therapeutic relationships with their patients was where the students felt that their contributions could be of greater value to the nursing team. The students in this current study described how they were considered an additional workforce to be 'tasked' by the registered nurses, but not as a valued member and part of the team.

"You're not allowing us to show you what we're going to make of ourselves as nurses and how we're going to come across to the patient if you're compounding us with 'get this done, make sure you do this.'

(Student FG 1. Pg. 2)

This statement clearly describes the frustration of one student while on clinical placement who felt unable to have his knowledge and skill recognised as more than tasks. Such a view has been supported by other research where student nurses explained that 'stepping in' and learning through interaction with the patient as a person, created the best learning opportunities (Currie et al. 2015). Being able to contribute to the nurse patient interaction in a meaningful way and having that contribution valued, provided the students an environment to deliver PCC.

It is suggested that learning to practice a PCC approach to nursing, one that is deeply respectful of the patient as a whole person, requires an approach to teaching and mentoring that is grounded in the same perspectives towards students. To learn to practice an approach to nursing that respects the patient as person, in other words, requires an approach to teaching and mentoring that respects the student as person.

From the point of view of the students who participated in this research, the experience of being accepted into the world of nursing through being valued as part of the nursing team emerged as an important and recurring theme. The sense of belonging this experience fostered was also identified as integral to supporting their development of the necessary skills and confidence to become successful practitioners of PCC.

### **Experiencing belonging in the workplace**

Levett-Jones and Lathlean (2008) argues that the most important influence in nurse education and clinical placement is experiencing a sense of belonging. In her study “Belongingness: A prerequisite for nursing students clinical learning”, Levett-Jones and Lathlean (2008) concludes that there is a need for strategies to enhance students’ belongingness and social wellbeing whilst on clinical placement. Such strategies can optimise the quality of the clinical placement experience and encourage students to devote their energy and attention into learning how to care for their patients. Students have been found to perform at their best when they are comfortable and safe and when they know their questions will be heard and answered without derision (Bradbury-Jones, Sambrook & Irvine 2011).

While I agree that belonging is fundamental to our sense of happiness and wellbeing this does not in and of itself constitute the only foundation for effective learning and mentoring in PCC. While clearly very important, to belong to the nursing team might simply mean that a student is well liked or, as has been

described previously, is hard working. Belonging is a deeply personal and contextual experience that encompasses how an individual feels accepted, valued and respected by a defined group. For learning to take place, the individual must feel that their professional and personal values are in harmony with the group (Levett-Jones & Lathlean 2008).

This discussion has thus far highlighted the importance of being valued by and belonging to the nursing team and the positive effect, this can have on student clinical experience in understanding and providing PCC. What needs to be considered here is the important role the curriculum plays in not only preparing the student for practice but in fostering a sense of self-worth and value that will assist them to socialise into the nursing team and to feel confident that they play an important part of any nursing team.

### **Nursing Curriculum and the application of Critical Social Theory**

The literature reviewed early in this study reflects widespread belief in the importance of caring as the central philosophy of a nursing curriculum. Based on this understanding, an important foundation for this study has been to establish how and to what extent PCC is being taught to students in the University of Adelaide Bachelor of Nursing program. The curriculum mapping exercise sought to identify patient centred terms evident within lecture titles and in content that focused on individual and tailored care to patients. This process revealed that the term 'patient centred approach' was a learning outcome in one course only, 'Nursing Older People.' Interestingly, despite an apparent very limited coverage of the wording of PCC across the curriculum many participants

were able to provide insightful and knowledgeable responses to the deeper questions of what PCC might look like.

Such a conclusion, however, raises a number of important issues for program review and development and for teaching and learning. As the review of contemporary nursing research has indicated, PCC is widely considered an important foundation to inform the delivery of quality patient care. It reasonably follows that on this basis PCC should be included intentionally and systematically into undergraduate nursing programs. As this research shows, however, little if any systematic coverage of the concept is incorporated into the University program. At best, students noted that it had been discussed informally in lectures and practical skills sessions.

While informal discussion constitutes a legitimate mode of learning, in effect, this is one strategy amongst many and is unlikely to lead to the deep or indeed informed learning Universities have the responsibility to deliver. Such learning requires comprehensive and demanding teaching and learning programs incorporating rigorous assessment tasks and access to quality research and professional experience designed to ensure the development of effective and informed practice. Students are thus challenged to develop deep understandings not only of the content of a particular approach such as PCC but also its rationale and purpose. It is through the experience of quality teaching and learning that undergraduate students are challenged to interrogate their beliefs and understandings. Such a process provides a very important foundation for the ongoing development of a well-informed

philosophy of nursing that ideally will continue to grow throughout the course of their working lives.

Of equal importance is to challenge our students to be autonomous, socially responsible and creative thinkers and to achieve this we need to move away from a behaviourist approach in our teaching to a more holistic and humanist approach. Critical social theory therefore provides the means to question the traditional more objective and mechanistic nature of nursing education and to challenge students to think outside the box and be creative with their practice and to realise their own ideas as being valued. Critical social theory encourages reflection on practice and a means to critique the power relationships in both nursing education and nursing practice. When applied to the nurse patient relationship the acknowledgement of human vulnerability of each individual means the nurse must be considerate with each social interaction. This approach leads to a patient centred approach to care and will result in greater satisfaction for the nurse and the patient involved.

### **Limitations of the research**

The data elicited from the students provided valuable insights into their experiences and highlighted some issues concerning PCC as it appears in practice. The assumption made in this study was that all students who volunteered for the focus group interviews would be open and honest with their responses.

It is acknowledged however that these views are from students from one education institution and one-year level therefore comment and comparisons



cannot be made about how these insights may have changed over time.

There were no quotas for the participants in this research therefore there may not be a balanced representative sample of the student nurse cohort.

All participants were only interviewed once and there was no further follow-up which would have enabled the students to reflect on the transcripts and to respond and clarify their statements.

## **Summary**

This research has explored the influence of clinical placement on the student's understanding of PCC. The initial hypothesis has been supported by the research and has described how student nurses are influenced by both the curriculum, the language used to teach PCC and the socialisation that occurs in the clinical environment.

The evidence suggests that there are three important factors that are fundamental to assist the student to focus on the patient as central to their nursing practice:

- The nature of the socialisation that takes place in the workplace.
- The importance of belonging to the nursing team.
- The importance of being valued for the work done and the contribution made.

Critical social theory has been the lens applied to this research as a means to critique the power structures that exist in the clinical environment and to explore how it might be used to emancipate the student nurse and empower them to

provide PCC. If tertiary nursing educators are committed to producing nurses who understand and know how to practice PCC then there exists, the need to pay careful attention to curriculum design and teaching strategies. The language of PCC needs to be more implicit throughout all courses and not taught discreetly in selected topics. This language and the enabling of mutual dialogue between both teacher and student needs to be synchronous with the teaching that takes place in the clinical skills environment where students have the opportunity to question practice and beliefs.

However, this alone is not enough as students are then exposed to the clinical environment where they are socialised into the institutional practices that occur in the workplace. Much work is needed to deconstruct the oppressive and coercive ideologies that exist in practice. It is important that we foster clinical partnerships with clinical leadership that maintains a dialogue between the university and the workplace that encourages mutual respect and understanding of diversity. This will empower our future nurses to find different ways of practicing where the patient becomes central to all nursing care, teamwork is fostered and student nurses are valued for the contributions they make to the nursing team. The ability to immerse themselves in the clinical environment to feel a sense of belonging and value will enable the students to realise their potential and will produce nurses who have holistic patient centered care as their core nursing philosophy.

## **Recommendations for further research**

Due to the findings from this study on the lack of formal recognition of PCC within the curriculum and aligned with the outcome of critical social theory the researcher is participating in developing a pilot project in the University's School of Nursing to teach a more focused approach to PCC utilising the Fundamentals of Care Framework (Kitson et al. 2010). This approach to teaching will utilise the Fundamentals of Care Template (Kitson, Muntlin Athlin & Conroy 2014) as the guide to integrate the nursing theory and practice.

Further research exploring how the institutional environment and the domination of the medical model imposes a structure of confinement and socialises the student which leaves little room for autonomous and socially responsible practice would be important. This would help to inform not only how we improve the way student nurses are prepared but would also enable dialogue necessary with our clinical partners to create cultural change for the benefit of the patients in our care.

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## **Appendices:**

Appendix 1: Ethics Approval

Appendix 2: Recruitment information flyer

Appendix 3: Participation Information Sheet

Appendix 4: Consent form

Appendix 5: Interview Questionnaire

Appendix 6: Example of Curriculum Mapping tool

## Appendix 1: Ethics Approval



RESEARCH BRANCH  
OFFICE OF RESEARCH ETHICS, COMPLIANCE  
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CRICOS Provider Number 00123M

9 October 2014

Dr L Cusack  
School: School of Nursing

Dear Dr Cusack

**ETHICS APPROVAL No: H-2014-224**

**PROJECT TITLE: What is the influence of clinical experience on the nursing student's understanding of patient centred care?**

The ethics application for the above project has been reviewed by the Low Risk Human Research Ethics Review Group (Faculty of Health Sciences) and is deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research (2007)* involving no more than low risk for research participants. You are authorised to commence your research on **09 Oct 2014**.

Ethics approval is granted for three years and is subject to satisfactory annual reporting. The form titled *Project Status Report* is to be used when reporting annual progress and project completion and can be downloaded at <http://www.adelaide.edu.au/ethics/human/guidelines/reporting>. Prior to expiry, ethics approval may be extended for a further period.

Participants in the study are to be given a copy of the Information Sheet and the signed Consent Form to retain. It is also a condition of approval that you **immediately report** anything which might warrant review of ethical approval including:

- serious or unexpected adverse effects on participants,
- previously unforeseen events which might affect continued ethical acceptability of the project,
- proposed changes to the protocol; and
- the project is discontinued before the expected date of completion.

Please refer to the following ethics approval document for any additional conditions that may apply to this project.

Yours sincerely,

**Sabine Schreiber**  
**Secretary, Human Research Ethics Committee**  
**Office of Research Ethics, Compliance and Integrity**

Appendix 2:



# MARCH & APRIL 2015 FOCUS GROUP DISCUSSION

Research project: Patient centered care.

Researcher/ Jan Alderman (Lecturer Bachelor of Nursing)

SCHOOL OF  
NURSING



THE UNIVERSITY  
of ADELAIDE

**Focus group discussion:**  
Please come and share your knowledge and expertise in this research study. You only need attend one 60 min session to participate.

Light refreshments will be provided at these sessions.

Question: What is the influence of clinical experience on the nursing students understanding of patient centered care?

SCHOOL OF NURSING  
Eleanor Harold Building  
Frome Road, Adelaide.

[Jan.alderman@adelaide.edu.au](mailto:Jan.alderman@adelaide.edu.au)

March - April 2015

## Appendix 3: Participation Information Sheet



### Participant information sheet and consent form.

Attention all 3<sup>rd</sup> Year Bachelor of Nursing Students.

Principle researcher: Jan Alderman HDR Candidate / University of Adelaide.  
This research is being conducted as part of my Masters of Clinical Science.

### Research project title

*What is the influence of clinical experience on the nursing student's understanding of patient centred care?*

You are invited to participate in a research project and before you decide whether to take part in the study it is important for you to understand why the research is being conducted. Please read this information sheet before you decide to volunteer to take part in this study. Participation in this project is completely voluntary and you may withdraw from the project at any time. If you do withdraw you can be assured that there will be no impact on you or your progress in this course. If you agree to participate you will be asked to sign a consent form to show that you understand and agree to your responsibilities as a study participant.

A copy of both the information sheet and signed consent form will be sent to you.

### Purpose of the study

Over time there has been a shift in our health care focus to one where a patient centred care approach is now at the forefront of the way we deliver care to our patients. There are many definitions of what patient-centred care means but they all share a common aim and desired outcome.

One such example is to describe patient centred care as "A collaborative effort consisting of patients, patients families, friends, the doctors, nurses and all other health professionals achieved through a comprehensive system of patient education where patients and the health care professionals collaborate as a team, share knowledge and work toward the common goals of optimum healing and recovery" (Grin, 1994)

This could present an onerous task for all health care professionals as our population ages and our incidence of chronic disease increases. The purpose of this research project is to identify what nursing students understand by the term "patient centred care" and to explore the influence clinical experience has on the perception of patient centred care as experienced by 3<sup>rd</sup> year nursing students. The intent of this study is to examine how student nurses reflect on the patient centred care approach that the curriculum has implied. It will also look at how the nursing students analyse the impact of the clinical placement environment on their delivery of PCC and identify the strategies nursing students use to enable them to deliver PCC whilst in this environment.

#### **Methodology of the research project**

The project will have two phases. Phase one will involve a curriculum mapping exercise where the University of Adelaide's Bachelor of Nursing curriculum will be examined to see where patient centred care is taught. Phase two will use focus groups, which involve the researcher bringing together a group of people to discuss a topic in a focused way. This project will use this methodology to generate some relaxed and informal discussions about how students experience PCC whilst on clinical placement. Focus groups used in this way can provide an opportunity to research not only peoples experience and attitudes but also allow them to be communicated in a comfortable and safe environment. It is important to note that as the research project supervisors do have a teaching relationship with the bachelor of nursing students the researcher will ensure that they will not have access to any data that might identify the students who volunteer in any way.

#### **Student involvement: What do I have to do?**

You will be invited to attend one discussion group meeting, which will take approximately 1 hour. During these focus group discussions, which will consist of no more than 8 students at a time, you will be free to stop and leave at any time. Should you choose to participate or not, please be assured that there will be no impact on your studies or progress in this course.

#### **How long will it take?**

Approximately 1 hour. Lunch and tea, coffee and filtered water will be provided for these sessions.

#### **Where and when will it occur?**

**Date:** April / Dates to be confirmed.

**Time:** I am proposing to hold these sessions on Thursday's from 1100 – 1200.

**Venue:** School of Nursing Meeting Room, Eleanor Harold Building EH3-30

#### **What are the questions about?**

The questions will focus on your understanding of the term "Patient Centred Care" and to explore your experiences of delivering this care whilst on clinical placement. In addition to this you will be asked to reflect on the impact the clinical environment has on your ability to provide PCC and to suggest or explain some strategies that you use to enable this to take place.

#### **What will happen when I come to the focus group discussion?**

When you come you will be asked to sign a consent form if you have not already done so providing the researcher with permission to use the information discussed as part of the focus group. The discussion will be audio-recorded and subsequently transcribed. Information gained from the group discussion will be written up in such a way that participants will not be identified in any subsequent publications arising from the research.

#### **Benefits to students**

There are no benefits to the students expected from participating in the study except possibly a deeper understanding about the curriculum and the importance of the relationship between theory and practice. Students may also benefit from their reflection on clinical placement in relation to the practice of patient centred care as this will help to empower them as they enter the workforce to be critical thinkers and pro-active in their decision making.

#### **What is the research about and how will this research help nursing students?**

This study will influence academic curriculum in the teaching of patient centred care to pre-registration students with the intention of inspiring graduate nurses to make positive changes in practice to engender a culture that supports and encourages a patient centred approach to care delivery. The

researchers aim to publish information about the study in a peer review journal article. Students will be notified via the School of Nursing newsletter when a publication is available.

#### **Risks**

There are no adverse outcomes anticipated from participating in the study, students may withdraw at any time without this adversely impacting on their studies.

You do not need to give a reason for withdrawing from this study.

You do need to notify the researcher that you are withdrawing.

If a student wishes to withdraw, their contributions to the discussion will be removed. The researcher anticipates that an independent observer will be present in the discussion who will take notes during the sessions. By doing this they will be able to identify the contributions made by each student. As these discussions will also be recorded the student will be identified by their voice.

Should the focus group discussion raise issues that are distressing for participants they will be offered counselling provided by the Student Counselling Service. Students will be advised that participants will not be identified in any subsequent publications arising from the research. Gender appropriate pseudonyms will be allocated to protect participant identify. Students who leave the focus group discussions prior to completion will have the right to refuse the use of their information.

#### **Ethical guidelines and approval**

The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2014-224). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. Contact the Human Research Ethics Committee's Secretariat on phone (08) 8313 6028 or by email to [hrec@adelaide.edu.au](mailto:hrec@adelaide.edu.au). If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

#### **HDR Research applicant:**

Jan Alderman, HDR Masters of Clinical Science Candidate, Office phone: 83131168

#### **HDR Research supervisors:**

Dr Lynette Cusack. Primary supervisor. Office phone: 83133593

Dr Frank Donnelly. Secondary supervisor. Office phone: 83133594



## Appendix 4: Consent form



Human Research Ethics Committee (HREC)

### CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

<b>Title:</b>	<b>What is the influence of clinical experience on the nursing student's understanding of patient centred care?</b>
<b>Ethics Approval Number:</b>	<b>H-2014-224</b>

2. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

3. Although I understand that the purpose of this research project is to improve the quality of nursing care, it has also been explained that my involvement may not be of any benefit to me.

4. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.

5. I understand that my participation in this research project will not have any adverse impact on any future assessment or progress in this course.

6. I agree to the interview being audio/video recorded. Yes  No

7. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

#### Participant to complete:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Researcher/Witness to complete:

I have described the nature of the research to \_\_\_\_\_  
(print name of participant)

and in my opinion she/he understood the explanation.

Signature: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

Appendix 5:

**Research question: What is the influence of clinical experience on the nursing students understanding of patient centred care?**

**Objectives:**

To understand what you know about a patient centred approach to nursing

To explore the influences both social and physical that have either supported or detracted from your ability to practice PCC whilst on clinical placement

Focus group questions: Patient Centred Care (PCC)

*Research question: What is the influence of clinical experience on the nursing students understanding of patient centred care?*

**Sample questions:**

**Objective 1**

To understand how nursing students reflect on the PPC approach that the curriculum has implied.

Tell me about you understanding of PCC? (This may need a definition if the students are unsure of this term)

**Definition:** PCC means that nurses need to engage with a patient's family, their beliefs and values, understand the patient's feelings, share the decision making with the patient and the family and provide the physical needs essential to promoting a healthy outcome for the patient.

Are you able to describe which courses in this nursing program that focus on a PCC approach to nursing? How is this taught or implied?

If you reflect on the time you have spent on clinical placement can you tell me where you have been able to provide PCC?

If you have not been able to provide patient centred care directly have you seen this done in any placement over the past 2 years?

Do your experiences of a patient centred care approach match what you have been taught in the classroom?

**Objective 2**

To explore how and to what extent nursing students reflect and analyse the impact of the clinical placement environment on how they apply PCC.

If you have practiced or seen PCC on any of your clinical placements can you describe how this looked, how was the patient and or family approached? Who was involved? (A scenario may need to be introduced here to identify what a patient centred care approach may look like)

**Definition:** a simple negotiation of when to get the patient out of bed for a shower and a discussion of what the day will entail, asking the patient if they are able to participate, asking them about what they would like to do first, do they want to wait for a relative to come in and assist or bring toiletries, accommodating the patient's wishes in the morning routine.)

If you have experienced PCC in practice can you describe what the outcome was for the patient?

Have you experienced any barriers that have prevented you from practicing in this way and can you explain what they might be?

In your experience what placement was better than others in supporting and practicing PCC? Can you explain why you think this occurred?

Are you able to recall a particular clinician or person who inspired you to provide PCC? What made them stand out for you?

### **Objective 3**

To identify the strategies nursing students use to enable them to deliver PCC while on clinical placement given the context they work in.

2 alternative questions depending on students experience PCC.  
What strategies have you used to enable you to provide PCC?

Prompts:

How did you overcome the demands of hospital routines?  
Did you involve the family in the discussions or decisions?  
What about time constraints and the demands of other patients and staff?

So the next time you are on clinical placement what strategies do you think you could use to enable you to provide PCC?

Prompts:

How might you approach your patients in the future?  
How will you overcome the demands of hospital routines?  
How will you involve the family in the discussions or decisions?  
What about time constraints and the demands of other patients and staff?

Appendix 6:

CURRICULUM MAP / THE BACHELOR OF NURSING UNDERGRADUATE PROGRAM:

Research Question: *What is the influence of clinical experience on the nursing student's understanding of patient centered care?*  
 Curriculum map identifying the core concepts of patient centered care.

COURSE NAME: Health Assessment and Clinical Nursing 1.	Lecture Content	Tutorial Content	Objectives	Assessments.	Patient centered care.
	<ul style="list-style-type: none"> <li>❖ Standard and additional precautions</li> <li>❖ An introduction to the fundamentals of care</li> <li>❖ Activities of daily living (showering, mouth, hair and ear care)</li> <li>❖ Activities of daily living (Nutrition and feeding)</li> <li>❖ Elimination (bowel and bladder care)</li> <li>❖ Vital Signs (temperature and pulse)</li> <li>❖ Vital signs (breathing and blood pressure)</li> <li>❖ Manual Handling (pressure area)</li> </ul>	<ul style="list-style-type: none"> <li>❖ Activities of daily living, Hygiene and bed making</li> <li>❖ Vital signs</li> <li>❖ Basic Life Support</li> <li>❖ Manual handling</li> </ul>	<ul style="list-style-type: none"> <li>❖ Demonstrate the key elements of a basic psychosocial assessment.</li> <li>❖ Perform basic nursing care interventions to support hygiene, nutrition and patient safety</li> <li>❖ Identify a range of numeracy skills and apply numeracy to simple drug calculations</li> <li>❖ Demonstrate effective basic interviewing skills.</li> <li>❖ Discuss the nurse's role in health</li> </ul>	<ul style="list-style-type: none"> <li>❖ Drug calculation diagnostic</li> <li>❖ Basic Life support test.</li> <li>❖ Clinical Skills book skills demonstration</li> <li>❖ NCAS</li> <li>❖ Employer Competency</li> <li>❖ Psychosocial Health Assessment</li> <li>❖ OSCE (Exam)</li> </ul>	

	<ul style="list-style-type: none"> <li>prevention)</li> <li>❖ Manual Handling Occupational health and safety.</li> <li>❖ Basic Life Support</li> <li>❖ Drug Calculations</li> <li>❖ Documentation</li> <li>❖ Basic Psychosocial Assessment</li> <li>❖ Normal findings of inspection, palpation, percussion and auscultation.</li> <li>❖ Cultural diversity and health assessment</li> <li>❖ Lifespan and health assessment</li> <li>❖ Gender differences and health assessment.</li> </ul>		<ul style="list-style-type: none"> <li>assessment.</li> <li>❖ Describe the normal findings of inspection, palpation, percussion and auscultation in health assessment of a patient.</li> <li>❖ Begin to recognise cultural, age, and gender related diversity in normal assessment findings.</li> <li>❖ Demonstrate the skills necessary to assess vital signs.</li> <li>❖ Demonstrate the key elements of a basic psychosocial assessment.</li> <li>❖ Demonstrate effective basic interviewing skills for the clinical setting.</li> <li>❖ Perform basic life support within a</li> </ul>		
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