THE IMPACT OF PRECEPTORSHIPS ON BACCALAUREATE NURSING STUDENTS’ PERCEPTIONS OF CARE

by

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A DISSERTATION

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Caring is a term that is difficult to define, yet is synonymous with the profession of nursing. Caring can be understood from two major dimensions, or domains, which are instrumental behaviors, comprised of technical and physical caring, and expressive behaviors, including the emotional and psychosocial elements of caring. Clinical education plays an important role in teaching nursing students care ethics throughout the curriculum. Preceptorships refer to a clinical component of nursing education where students are involved in a mentoring relationship with a professional nurse, in which the professional nurse relates information and knowledge to the student to prepare them for their future career. The purpose of this quantitative study was to examine how time spent in a preceptorship experience changed the senior-level nursing students perception of caring. In addition, different types of clinical units and preceptors were explored as a means to changing caring perceptions of the students. The sample included final semester, senior-level nursing students (n=31). Caring perceptions were measured using the Caring Dimensions Inventory (CDI-25). The results of the statistical analysis (Spearman’s Correlation Coefficient, t-test, and descriptive statistics) found a significant relationship between the years of experience of the nurse preceptors and students’ perception of care, but no significant difference in caring perceptions after the preceptorship experience. Descriptive statistical analysis revealed higher CDI-25 scores for students in certain clinical units and for those with a nurse preceptor identified as a facilitator. The results of the study demonstrated that nursing preceptorships can play an integral role in providing caring ethics education within the nursing curriculum.
DEDICATION

I would like to dedicate this dissertation to my precious family. To my husband, Corey, you have been the biggest supporter and encourager through this process. Thank you for your patience, guidance, and the countless hours of proofreading every paper I wrote in this doctoral program. You deserve your own doctoral degree. Thank you for taking care of our family while I pursued this dream.

To my daughter, Georgia, I am so thankful for the Lord’s perfect timing with you. You have been my favorite distraction these past two years. I pray you will always trust in the Lord and know your worth. Always set your goals high and believe that you can achieve anything.

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Finally, I would like to dedicate this dissertation to my late grandfather, Chester Ray Salmons. You taught me that a solid education is something that no one could ever take away from me. I wish you were here to watch me walk across the stage.
# LIST OF ABBREVIATIONS AND SYMBOLS

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Definition</th>
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<tbody>
<tr>
<td>$df$</td>
<td>Degrees of freedom: The number of sample values free to vary about a parameter</td>
</tr>
<tr>
<td>$n$</td>
<td>The symbol designating the number of subject in a study group</td>
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<tr>
<td>$p$</td>
<td>The probability that the obtained results are due to chance alone</td>
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<tr>
<td>$r_s$</td>
<td>Spearman’s correlation coefficient: A correlation coefficient indicating the magnitude of a relationship between variables measured on the ordinal scale</td>
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<tr>
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<td>Less than</td>
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CHAPTER I:
INTRODUCTION

Caring is considered a universal phenomenon, where every human has the ability to care (Sokola, 2013). This ability to care comes from personal experiences of being cared for and then in turn caring for others; however, this does not mean that everyone cares in the same manner (Watson, Deary, & Lee, 1999). The simple, yet profound and complicated word *caring* has been synonymous with nursing since the foundational days of the profession. Nursing is known as the caring profession because of decades of utilizing caring as the foundational concept behind the practice, despite a lack of a harmonized meaning of the term (Sargent, 2012). Duffy (2003) explained caring as a generic attribute experienced in all cultures between family and acquaintances; however, the caring that exists within nursing practice is embedded into the daily work of nurses with the purpose of health and healing.

As students enter nursing programs, it is the desire that they expand his or her caring abilities to more professional and technical caring abilities (Sokola, 2013). The expansion of caring domains is believed to come from students interacting with patients, faculty, and peers to create new experiences and knowledge (Kapborg & Bertero, 2003). Sokola (2013) believed that professional caring involves both technical and attitudinal aspects that may be learned by nursing students through practice. Through contextual experiences and becoming more self-aware, nursing students can incorporate more professional and technical aspects of caring into practice (Sokola, 2013). This, in turn, may aid students to meet today’s ever-expanding healthcare needs.
Florence Nightingale, often described as the Mother of Nursing, suggested that clinical practice should be at the center of a nurse’s professional development (Sedgwick & Harris, 2012). During Nightingale’s time, nursing schools were hospital-based and all training took place in the hospital setting. As nursing became part of the higher educational institution, clinical instruction was used to bridge theory with practice (Duteau, 2012; Udlis, 2006). Nursing preceptorships, or practicums, are a form of clinical experiences that facilitate the bridge to professional nursing practice. In traditional clinical education, learning is focused on a group with a teacher-centered approach, while the preceptorship model focuses on the one-on-one relationship between the student and a mentor.

In the 1980s, the preceptorship model emerged as a prevalent alternative to the traditional, supervised clinical model and is currently endorsed by groups such as the American Association of Colleges of Nursing and the Canadian Nurses Association (Duteau, 2012; Udlis, 2006). The term preceptorship refers to a mentoring relationship between a student and a professional nurse in which the professional nurse relates information and knowledge to the student to prepare them for their future career. Preceptorships are designed to build a student’s confidence and knowledge base prior to graduating nursing school and entering the workforce (Udlis, 2006).

**Statement of the Problem**

Since the 1970s, nursing theorists have attempted to define caring as related to professional nursing practice. Sitzman (2007) noted, “References to caring in nursing literature are so ubiquitous that it is difficult to form one inclusive definition of the term as it relates to nursing” (p. 8). In an attempt to define caring as it relates to nursing practice, scholars have continued to create new definitions based on philosophical and scientifically observable actions,
while also deepening the understanding of the concepts and how they are related to professional nursing. This ongoing debate over a centralized definition of caring concepts has been challenged by varying interpretations throughout the literature based on nursing expertise, level of education, location of practice and professional focus, in addition to the personal values of those providing care (Sitzman, 2007). There is also the complicated belief that caring is purely based on the action of the nurse and is not an inherent value (Porr & Egan, 2013).

Currently, nursing education is being forced to find alternatives to clinical education hours due to an increase in nursing student enrollment and a shortage of both clinical sites and qualified faculty; however, clinical experience remains one of the most important foundations to nursing education (McNelis et al., 2014; Nehring, 2008, Rich & Nugent, 2010; Schoening, Sittner, & Todd, 2006). It has become increasingly difficult to find the correct balance between theoretical classroom-based knowledge and experience-based clinical knowledge. Robinson and Dearmon (2013) noted that it is becoming even more difficult to continue to support increased student enrollment and a traditional clinical model.

As the amount of clinical hours in nursing education continues to be reduced, the amount of time students spend with actual patients is also decreasing (Waldner & Olsen, 2007). Ethical dilemmas, socioeconomically factors, and advances in technology within the complex health delivery system call for a profession that is equipped with ethical problem solving and moral reasoning skills, yet there is little evidence on the best method to convey caring ethics to nursing students (Blum, Hickman, Parcells, & Locsin, 2010; McLeod-Sordjan, 2014). Caring, as the foundational principle in nursing, can be taught and theorized within the boundaries of the educational institution, but students struggle to transform the knowledge of caring behaviors and attitudes into practice without witnessing the modeling of behaviors and hands-on practice with
patients (McLeod-Sordjan, 2014). Students are expressing emotions such as fear, stress, and overwhelm due to the lack of experience and practice in the clinical setting (Harrison-White & Simons, 2013; Rhodes & Curran, 2005).

In addition, the profession of nursing is facing a unique set of problems due to an ever-changing healthcare environment (Rhodes & Curran, 2005). The original duty of the nurse was to provide care to the ill; however, in recent years, the profession has seen an expansion of the roles and duties of the nurse (Akansel, Watson, Aydin, & Ozdemir, 2012). Even though there is a long held assumption that nurses are naturally caring, studies are showing that patients are noticing an absence of compassionate attitudes displayed by graduate nurses (Porr & Egan, 2013; Vanlaere, Coucke, & Gastmans, 2010; Wood, 2014). Wood (2014) suggested that contemporary nursing care is experiencing new challenges due to increasing duties and responsibilities that leave minimal time to deliver compassionate care to individuals.

Many employers expect new graduates to assimilate into their new roles quickly and effortlessly; however, the reality of transitioning from a nursing student to a professional nurse is difficult. In the educational setting, students are protected and guided in a safer environment, which is different from the professional world where every action and decision has a consequence. Multiple comorbidities, cultural challenges, and technological advances provide a challenging and ever-changing work environment that makes it even more difficult for new graduates to transition to their roles (Robinson & Dearmon, 2013).

Preceptorships, which have been used for decades as an alternative to the traditional clinical model, offer a positive way to introduce real-life scenarios to students before graduation. Several studies (Natale & Klevay, 2013; Sandvik et al., 2014; Wieland, Altmiller, Dorr, & Wolf, 2007) have been conducted on the benefits of preceptorships in nursing education; however,
there is little published on the most appropriate amount of hours for preceptorship (Kuiper, Murdock, & Grant, 2010). There are no mandatory clinical hours or preceptorship hours regulated by nursing supervisory agencies; instead, individual boards of nursing regulate the hours. Spector (2012) found only seven boards of nursing have a mandatory amount of clinical hours for baccalaureate nursing programs while Kuiper et al. (2010) noted that only two state nursing boards, Kentucky and North Carolina, have a requirement for nursing preceptorships. In addition, Harrison-White and Simons (2013) acknowledged that clinical pressures and local provisions are limiting the time for pre-graduation preceptorship experiences.

In addition, there are limited studies on the qualities of professional preceptors in nursing (Courtney-Pratt et al., 2011). Characteristics of the preceptor such as educational background, and number of years and types of experiences in the nursing profession and descriptions of the type of units in which the students are precepting could lend itself to rich descriptions of how these characteristics correlate with student caring perceptions.

**Purpose of the Study**

The purpose of this study was fourfold: 1) to determine if there was a relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience; 2) to determine how senior-level baccalaureate nursing students’ perception of caring compared among the primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience; 3) to determine how senior-level baccalaureate nursing students’ perception of caring compared among varying clinical units after a 225-hour preceptorship experience; and 4) to determine if there was a difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate
nursing students’ perception of caring after a 225-hour preceptorship experience. Rather than broadly looking at how caring attributes change during an undergraduate nursing program, research was conducted to examine how interactions within a specific clinical experience altered nursing students’ perception of care. Overall, the purpose of the study sought to explore what, if any, qualities of a preceptorship experience changed the ways in which baccalaureate nursing students perceived caring.

Theoretical Framework

The theory of symbolic interactionism, influenced by George Herbert Mead, was used to guide this study. Symbolic interactionism explores the meanings placed on the interaction with others and the behaviors that ultimately reflect the interpretations (Vejar, 2009). Symbolic interactionism provided a lens to view how caring ethics can be taught within the nursing curriculum, specifically within relationships with registered nurses in varying clinical environments. Symbolic interactionism also allowed the researcher to gain information regarding how caring dimensions, as perceived by the student, changed in relation to time spent in a preceptorship experience. Knowledge that caring holds different meanings to individuals is an important concept when teaching caring ethics.

Research Questions

The research questions for this study were as follows:

1. What is the relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience;
2. How do senior-level baccalaureate nursing students’ perception of caring compare among primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience;

3. How do senior-level baccalaureate nursing students’ perception of caring compare among varying clinical units after a 225-hour preceptorship experience; and

4. What is the difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience?

Overview of Methods

This quantitative study explored how time spent in preceptorship changed the caring perceptions of students prior to graduation from one baccalaureate nursing program. The study also explored the relationship between the years of experience of a registered nurse preceptor and the perception of caring of senior-level baccalaureate nursing students. In addition, the study compared characteristics of the preceptorship, such as the type of clinical unit and the primary teaching style, as perceived by the student, of the nurse preceptor, to the senior-level nursing students’ perception of caring. Participants were recruited through convenience sampling of senior-level nursing students from one Baccalaureate degree nursing program in the southeastern United States.

Data were collected through a self-administered online survey using Qualtrics, a Web-based survey application. The data collection occurred on two separate occasions, one prior to the preceptorship experience, and one post-preceptorship experience, using the Caring Dimensions Inventory (CDI-25). The CDI-25 was developed by Watson and Lea (1997) to
gather information concerning nurses’ perception of caring. The tool consists of 25 operationalized statements of nursing actions that were designed to gain an understanding of the dimensions of caring, more specifically, what constitutes care. The responses to the prompt question of do you consider the following aspects of your nursing practice to be caring were given on a 5-point Likert scale ranging from 5= strongly agree to 1= strongly disagree. Scoring for the tool can range from 25-125. The higher the score on the CDI-25 demonstrated nurses’ belief that professional and technical aspects of nursing were perceived as more caring, while lower scores indicated psychosocial aspects are perceived as more caring (Watson & Lea, 1998). The CDI-25 was chosen as an instrument for this study in order to gain an understanding of how nursing students perceive caring, not necessarily how the students care.

In addition, a short questionnaire regarding the descriptive characteristics of the preceptor and precepting environment was included in the data collection process. Items such as the type of unit the student was placed on and the years of experience as a Registered Nurse of the nursing preceptor were asked in the questionnaire. Participants were also asked to choose the primary teaching style that most closely matched his or her preceptor’s teaching style. These questions allowed the researcher to determine characteristics of the preceptor and preceptorship that influenced a change in caring dimensions as perceived by the nursing students.

**Significance of the Study**

Many studies within the literature have recommended more research emphasis be placed on discovering ways to teach caring ethics and behaviors in nursing education (Doyle, Hungerford, & Cruickshank, 2014; Khouri, 2011; Ma et al., 2013). The researcher explored interactions within the preceptorship experience as a means of providing caring ethics education to students. This study has far-reaching implications for nursing education as it will demonstrate
the importance of hands-on clinical education in strengthening professional caring behaviors of nursing students. In addition, the study provides indications for specific hospital units and certain qualities of registered nurse preceptors to help design quality preceptorship experiences that also contribute to caring ethics education of nursing students.

**Definition of Key Terms**

Due to varying definitions and understandings of readers, several key terms are defined. These terms aid in the reader’s understanding of the study and are helpful in defining the researcher’s use of certain terms in the context of this study. In the present study, the following theoretical and operational terms were utilized.

*Caring* is a term that is difficult to define due to the multiple perspectives from which it is understood and the various actions the term includes (Watson, Deary, & Lea, 1999). For this study, the term *caring in nursing* is defined as an action that is both contextually depended and value bound, encompassing both expressive and emotional components in addition to the instrumental, or physical acts of labor. Caring comprises both “being with” a patient and “doing for” a patient. The definition of caring is derived from the theoretical viewpoints of Lea, Watson and Deary (1998). The term is operationalized through the use of the Caring Dimensions Inventory (CDI-25).

*Caring dimensions* are defined as the physical and emotional labor of caring (Watson, Deary, & Lea, 1999). Caring dimensions is operationalized through the use of the CDI-25. Caring dimensions are measured through the use of Mokken scaling, where higher numbers demonstrate a technical and professional perception of care, while lower scores demonstrate a more expressive and psychosocial perception of care.
Clinical experiences are defined as planned learning activities in nursing practice that allow students to understand, perform, and refine professional competencies at the appropriate program level (CCNE, 2016). Clinical experience allows students to utilize kinesthetic learning techniques to connect classroom knowledge and clinical skills, while being supported by registered nurse staff members and educators (Sandvik, Eriksson, & Hilli, 2014).

Ethic of care is defined as “an ethic where moral situations are defined not in terms of rights and responsibilities but in terms of relationships of care often within challenging contextual circumstances” (Woods, 2011, p. 271). Ethics of care provide a strong foundation for providing certain concepts such as, empathy, prudence, compassion and affection to patients, within the nursing profession.

Preceptee is defined as a student in a nursing program who is assigned to work with a registered nurse (Myrick & Yonge, 2001). The preceptee is involved in a mentoring relationship with the preceptor for the purpose of observing and learning proper behaviors and actions to better improve their own practice.

Preceptor is a registered nurse who guides and instructs student nurses in the clinical setting for various amounts of time. The preceptor determines the climate of the overall preceptorship experience for the student (Myrick & Yonge, 2001). The preceptor must provide an environment that is stimulating and caring to support a professional and authentic relationship to facilitate learning (Myrick & Yonge, 2001; Shepard, 2009).

Preceptorship refers to a relationship between a student and a professional nurse, in which the professional nurse relates information and knowledge to the student to prepare them for their future career (Udlis, 2006). Preceptorships offer students the unique experience of
working one-on-one with an experienced nurse in the clinical environment, while also being supported by nursing faculty (Luhanga et al., 2010; Udlis, 2006).

**Summary**

As students enter nursing programs, it is the desire that they expand his or her caring abilities to more professional and technical caring abilities (Sokola, 2013). Moyano (2015) argued that care ethics can easily be taught as a concept, but there is marked difficulty when putting ethics into practice. Preceptorships, which have been used for decades as an alternative to the traditional clinical model, offer a positive way to introduce real-life scenarios to students before graduation. This study examined how the amount of hours, types of units, and the years of experience and primary teaching style of the registered nurse preceptor changed the senior-level nursing students’ perceptions of caring following a 225-hour preceptorship experience. This study also sought to explore the role of interactions during hands-on clinical education in strengthening professional caring behaviors of nursing students.
CHAPTER II:

REVIEW OF THE LITERATURE

Introduction

A thorough literature review is important to gain knowledge of what studies have been conducted on the certain topic and what recommendations the researchers suggest for future studies. For the purpose of this literature review, a comprehensive understanding of caring within the profession of nursing is important, including an extensive review of caring theories. Existing knowledge of how caring ethics are being taught in nursing education, in addition to any studies than can link clinical preceptorships to caring ethics knowledge are crucial to building a foundation for this research.

Currently, there is a large amount of literature concerning the topic of caring in nursing (Khouri, 2011; Lundgren & Berg, 2010) with additional studies on fostering caring abilities and behaviors through nursing education (Higgins, 1996; Milnar, 2010; Sargent, 2012). However, a review of the literature revealed few studies addressing preceptorships in nursing, and no studies on the topic of nursing preceptorships’ effect on caring perceptions using the search strategies listed in the following section. The review focuses on evaluation and synthesis and explores four main topics: 1) the definitions of caring, including a review of caring theories, with a focus on how caring and nursing are related; 2) the effects nursing education has on caring abilities and behaviors; 3) educational efforts and intervention programs that facilitate caring in nursing
students; and 4) a description and analysis of preceptorship programs that are currently utilized in nursing education.

**Search Method**

A literature review was conducted by searching the databases CINAHL, Google Scholar, ERIC, and ScienceDirect. The search terms caring, caring in nursing, caring ethics in nursing, caring theories in nursing, caring abilities in nursing, caring in nursing education, teaching caring in nursing education, preceptorships in nursing, nursing preceptorships and caring, nursing preceptorships and caring abilities and behaviors were utilized to gather relevant research articles. In addition, reference lists from the selected articles were examined for additional literature. Studies were chosen based on publication dates within the last ten years, but seminal pieces were also considered according to relevance to the topic.

**A Historical Perspective**

A look into the history of nursing revealed the profession is rooted in the philosophy of healing people. The term nurse was derived from the Latin word nutricius, which is associated with nourishing, cherishing, and caring (Wagner & Whaite, 2010). Florence Nightingale never defined or described the function of the term caring, although she used the term to suggest one aiding in the healing and survival of patients through a clean environment, food, rest and exercise. A closer look into Nightingale’s works reveals she believed that nursing was both an art and a science. There is a science behind the treatments of patients, but there is an art to caring for and healing those in need. She also suggested through her writings that five themes could be associated with a caring relationship and nursing, which are to attend to, give attention to, be genuine, be competent, and nurturing (Wagner & Whaite, 2010).
Since the days of Nightingale nursing, much has evolved in the both the duties of nurses and the definition of caring. A theoretical movement, which began in the 1980s, demonstrated a new emphasis on caring in nursing. The important theories of Leininger and Watson emerged claiming that caring was the central focus of nursing (Murphy, Jones, Edwards, James, & Mayer, 2009). Nelms, Jones, and Gray (1993) also noted that the 1980s and early 1990s was a time for deep investigation into the concept of caring in nursing.

Nursing education continues to evolve and change. Students no longer train and live within the hospital, which once housed nursing education. In fact, many students do not even have the chance to practice within the hospital setting until they are well into the nursing education program. There have been many positive aspects to withdrawing nursing programs from the hospital controlled setting to the educational institution; however, this has left students with limited access to practice with real patients (Waldner & Olson, 2007).

**Defining Caring**

The term care comes from the Latin term cogitatus, meaning reflection or thought. The act of caring can be deduced to an action that helps one before the need of another (Moyano, 2015). It would be easy to reference a dictionary for the definition of the term, but caring, as it relates to the nursing profession, requires more thought and reflection.

Since the 1970s, nursing theorists have continued to develop caring models related to professional nursing practice in hopes of developing one centralized definition of caring. Sitzman (2007) noted, “References to caring in nursing literature are so ubiquitous that it is difficult to form one inconclusive definition of the term as it related to nursing” (p. 8). Caring is a term that is both culturally and contextually bound. Lundgren and Berg (2010) suggested that all humans have experienced caring within the boundaries of the family unit and most have
experienced care by and from a professional. Caring has been associated with a positive emotion, while some connect it with protective actions and concerns (Duffy, 2003). Khademian and Vizeshfar (2007) believe caring is related to a moral stance and that care models morals of nursing.

Lundgren and Berg (2010) suggested caring is a natural human behavior, and it is fundamental to existence, yet it is a term that is used often but frequently misunderstood. In addition, Sitzman (2007) suggested that the terms care and caring have become so misused and common that the meanings have lost value. There is uniqueness of the term caring because each human has experienced a different way of being cared for. The problem with attempting to define the term caring lies in the uniqueness of individuals’ previous experiences and emotions (Lundgren & Berg, 2010).

Watson, Deary, and Lea (1999a) explored the conceptualization of the term caring by stating, “A single definition of caring is an unlikely prospect due to the multiple perspectives from which it is viewed and the range of action which it encompasses” (p. 1081). In an earlier paper, Lea, Watson, and Deary (1998) explained caring in nursing as an action that is both contextually depended and value bound, encompassing both expressive and emotional components in addition to the instrumental, or physical acts of labor. Caring comprises both being with a patient and doing for a patient. Caring is foundational based on the relationship with the patient.

In an attempt to define caring as it relates to nursing practice, scholars have continued to create new and complimentary definitions based on philosophical and scientifically observable actions, while also deepening the understanding of the concepts and how it related to professional nursing. Khouri (2011) explained caring as, “being open to and perceptive of others,
being genuinely concerned about patients, being morally responsible, being truly present for patients, being dedicated, and having the courage to be appropriately involved as a professional nurse” (p. 174). She also stated that in modern-day culture, the terms “nursing” and “caring” seem to be synonymous with one another. Boykin and Schoenhofer (1993) described nursing as a “unique lived form of caring” (p. 23).

Perhaps the most encompassing view of caring is from the following a meta-synthesis by Finfgeld-Connett (2008) summarized by Griffiths et al. (2012):

Caring is a complex interplay between expert nursing practice, interpersonal sensitivity and intimate relationships. Each element is multi-faceted with expert nursing practice encompassing, for example, excellent assessment skills and empowerment, interpersonal sensitivity describing centering completely on the patient, non-judgmentally and with openness and availability and intimate relationships becoming deeply involved with patients and their families and sharing personal thoughts and feelings, whilst avoiding crossing the line into a ‘personal’ relationship. (p. 125)

This synthesis of caring displays a multi-dimensional view of caring. It not only mentions the technical aspect of caring for individuals, but also mentions the involvement of thoughts and feelings into the care. This definition provides a strong foundation for this present study, as it demonstrates the need for multiple facets of caring.

Caring Theories

The ongoing debate over a centralized definition of the concept has been challenged by varying interpretations throughout the literature based on nursing expertise, level of education, location of practice and professional focus, in addition to the personal values of those providing care (Sitzman, 2007). A close look at prominent nursing theorist and the theories of caring can lend itself to a more comprehensive understanding of the term caring.

McCance, Slater, and McCormack (2009) suggested foundational theories on caring are based on human science principles such as philosophy of human freedom, choice and
responsibility, human relationships, and the connections one makes with others and the surrounding environment. Theories on caring and caring ethics continue to be established and expanded upon in the current literature. Theorists such as Nissen, Erikkson, and Noddings continue to influence many of the thoughts and works of other theorist in modern culture.

Ulrikke (Rikke) E. Nissen was one of the founders of nursing as a professional in Norway in the 1800s. Nissen utilized the term caring in many of her works; however, she never defined the term because she believed it was rooted in Christian philosophy. She believed caring for the sick and poor must be the foundation for nursing practice as it relates to Christian love. Despite the need for a theoretical and knowledge-based profession, Nissen believed caring elevated nursing to an art, instead of only a craft. She also believed that caring is innate in every human, but many do not realize their potential to care. Nissen correlated the skills required to practice nursing care to the qualities that characterize the nurse as a person, such as the ability to make observations, be brave and composed, have presence of mind and to possess qualities of patience, love, wisdom and humility. She believed nursing care should have both intellectual and practical dimensions (Austgard, 2008).

Austgard (2008) also noted that Nissen’s understanding of nursing care had a foundation in professional nursing judgment that was broken down into separate dimensions. The moral dimension described the concept of empathy. She also commented on the aesthetic dimension, which she claimed has no place within professional nursing judgment. The preferences and attitudes of nurses, such as what he or she likes or does not like, has no place in professional judgment.

Kari M. Martinsen was another philosopher that believed professional judgment is central to the idea of nurse caring. As a nurse philosopher, Martinsen defined care as an ontological
phenomenon with a universal appeal. She thought of caring as a moral practice, yet deeply rooted in professional knowledge. Martinsen (2000) stated, “Without professional knowledge, concern for the patient becomes mere sentimentality.” She also believed that morality is deeply rooted between the patient and the nurse. The nurse must recognize the beliefs and individuality of the patient to actually care for them. It is the holistic view of the patient that must be considered when caring in a professional relationship. In addition, professional caring is best learned in practice under the guidance and supervision of nursing role models (Austgard, 2008).

Although Nissen and Martinsen presented their theories on caring in different manners, both theorist infer a common understanding of professional care in that a nurse must holistically view the patient in order to truly care for his or her needs. Each patient should be viewed according to his or her subjective experiences that he or she holds. Nissen and Martinsen shared the view of caring from a humanistic perspective, where values such as compassion, love and trust create a caring encounter (Austgard, 2011).

Eriksson also believed in the ethics of empathy as an underpinning for professional nursing practice. Eriksson’s philosophical stance on caring is based on the notion of dignity of the human being. A person is not able to care or nurture another unless they understand the concept of suffering in others (Austgard, 2008). Eriksson believed the two basic motivators of caring are compassion and human love and the meaning these have are dependent on interpretation. To give or receive care, as defined by Eriksson, is dependent on the interpretation of the individual (Eriksson, 2002).

Nel Noddings, one of the first theorists to explain caring in relation to education, believed caring to be the highest level of moral development (Cohen, 1992; Labrague et al., 2015). She considered caring an inter-relational concept, based on a mutually emotional response. Caring
relies on the connectedness of the one caring and the cared for (Noddings, 2003). She believed nursing education should be grounded in the ethics of care (Cohen, 1992). Noddings considered caring curriculum as being formed through the integration of caring views and specific fields of professional knowledge (Lee-Hsieh et al., 2004). In Nodding’s transdisciplinary model of human caring, she outlined four components to teaching caring, which are modeling, or observable action, dialogue, opportunities for practice, and feedback to caring events (Labrague et al., 2015).

Noddings’ theory is an important component in ethics and caring education. A look through the lens of Noddings’ theory will also lead to the assumptions on symbolic interactionism. Students can learn what care looks like in the classroom setting, but until he or she is actually interacting in a relationship with a patient, professional caring cannot occur.

Simone Roach wrote a publication on human caring in nursing in 1984. Her concepts and beliefs on nursing have never become an official caring theory, but many quote her work for the development in the conceptualization of caring in nursing (McCance et al., 1999). Roach believed caring to be the human mode of being. In her writings, Roach defined care as the professionalization of human caring through the development of skill acquisition and expression (McCance et al., 1999).

Roach (1984) developed the five ‘C’s’ of caring, which are compassion, competence, confidence, conscience, and commitment. She believed these five concepts are the true attributes to caring. The concepts do not explain just one aspect of caring, but instead, they explain an entire conceptual understanding of caring. According to Roach, one cannot care by simply showing compassion to an individual. The person must instead have competence and professional knowledge, while also using ethical decision-making to uphold the extraordinary
responsibilities and standards of the nursing profession. Roach also believed that caring is not unique to nursing, but it is unique in nursing. She proposed that nursing was not the caring profession, but instead the helping profession (McCance et al., 1999). The five concepts and the conceptualization of caring in nursing provide a valuable definition of caring that was utilized through the present study.

Jean Watson (2013), known for her Theory of Human Caring stated, “Effective caring promotes healing, health, individual/family growth, and a sense of wholeness, forgiveness, evolved conscientiousness, and inner peace that transcends the crisis and fear of disease, diagnosis, illness, traumas, life changes, and so on” (p. 250). Watson’s theory supports the element of transpersonal caring, where the mind, body and soul of an individual must be involved in transpersonal interaction (Sokola, 2013). Watson believed caring for others is dependent on the ability to first care for one’s self. Watson (1999) noted that caring is based on relationships and transactions with the other.

Each of these philosophers and researchers have added valuable theories to the caring literature. Many of the philosophers have states their belief that caring not only involves the emotional and altruistic side, but also a certain professional characteristic. Jean Watson’s theory aligns with this notion of combining ethics and technical skills to demonstrate caring to individuals. Watson also believed that altruistic and humanistic values were learned throughout life and may be influenced at any point. These influences may come from nurse educators and professional role models (Austgard, 2008). Watson also believed that nurses need both inherent and professional caring that merge ethics and values with technical skills that are learned through interactions in practice (Sokola, 2013). Her philosophy opened the door for more research into the links between professional practice and the concept of caring.
The underpinnings of Jean Watson’s philosophy was used as a lens to view holistic caring in the present study. Caring should not be viewed as a unidimensional construct, but instead, it should be viewed from both the psychosocial aspect and the technical aspect. Professional practice and expertise cannot be overlooked as a component of caring. One cannot simply provide emotional support to patients without the technical component to promote healing. In addition, it is through the interactions within nursing school and into practice that shape how others perceive care. Watson’s theory provides an appropriate lens to view the multidimensional focus of caring through interactions within the clinical setting.

**Caring Ethics and Professional Judgment**

Caring as an ideal can be subjective when it comes to an ethical perspective. Hawke-Eder (2017) argued that caring leads to relativism, or an absence of absolutes that complicates all moral decision-making. Caring ethics were described by Woods (2011) as “an ethic where moral situations are defined not in terms of rights and responsibilities, but in terms of relationships of care often within challenging contextual circumstances” (p. 271). Woods (2011) stated that caring is the philosophical, practical and ethical foundation of nursing. Through a care ethics lens, theories of nursing care have been developed over the past several decades that help discern the profession from medicine. However, there is cited difficulty in applying ethics of care into actual nursing practice (Moyano, 2015). Nursing theories and models can be complex due to the theoretical nature; however, the theoretical foundation is what establishes the principle of professional work.

Lee-Hsieh, Kuo, and Tsai (2004) also believed professional care involves scientific knowledge, skills and actions. It requires not only the understanding of care that a person brings to the nursing profession, but also a component includes professional morals and ethics. Khouri
(2011) also agreed that caring is a multifactorial process that involves professional knowledge, competence, skills and actions on the part of the nurse. Pedersen and Sivonen (2012) believed that during nursing school, student’s capacity for care is professionalized. This supports the notion that the ethical formation process advances the students’ moral integrity and personal caring ethics.

Moyano (2015) also argued that care ethics can easily be taught as a concept, but there was marked difficulty when putting it into practice. Woods (2011) also noted that in the clinical setting, care ethics are difficult to implement due to constraining circumstances. Even with the challenges, Moyano (2015) and Woods (2011) agreed the ethics of care should provide a strong foundation for providing certain concepts such as empathy, prudence, compassion, and affection to patients. Moyano (2015) believed that nursing as a profession lacks a bioethical lens, but by the instillation care ethics into nursing, the profession could be given more meaning.

Throughout the literature review, the topic of empathy and how empathy changed how patients viewed caring came up on several occasions. Rego et al. (2010) suggested nurses displaying empathy are more perceptive to patient needs. By appreciating the perspective of the patients, nurses are able to better understand and meet needs by connecting with them. This allows for a better reaction from the professional nurse. Empathy may be discussed within the realms of theories and discussions, but it requires interactions in practice. As Nissen and Martinsen explained within their theories of caring in nursing, interactions between the nurse and patient produce caring connections.

Doyle et al. (2014) described many instances of poor physical and mental outcomes of patients in the United Kingdom and Australia due to nurses’ lack of empathy. The authors noted in the past, the term empathy referred to a fundamental quality of all nurses, but more recently,
empathy refers to a behavioral quality signifying the understanding of an experience or perspective of others. The problem with teaching empathy is it cannot be practiced without the interaction between the caregiver and the one being cared for. The findings did suggest that educators strengthen the affective domain of attitudes during instruction.

**Multiple Demands on Nurses**

The professionalism shift in nursing had led some theorists to question if traditional caring qualities are being exchanged for scientific and technological caring. Many patients may perceive this type of professional caring as just ‘doing the tasks’ and describe it as ‘noncaring’ (Hawke-Eder, 2017). Other theorists have noted the importance of establishing professional and meaningful relationships with patients (Austgard, 2008; Duffy, 2003; Noddings, 2003; Martinsen, 2000; Sokola, 2013). Specialized knowledge and human interaction is a key component of nursing that sets the profession apart from other health related fields. Austgard (2008) suggested the meaning and definition of care must come from a superordinate level that can incorporate all aspects of care and discern care from non-care. In nursing, listening to and valuing the beliefs of the patient is the core concept behind the ethics of caring. However, patients still need the specialized skills and knowledge that only nurses can provide. This demonstrates the need for not only compassionate care, but also for knowledgeable and technical care.

However, nurses are voicing frustration at the inability to deliver compassionate care due to inadequate staffing leading to higher nurse-patient ratios and an over-emphasis being placed on government mandated ‘targets’ that determine hospital reimbursement (Hawke-Eder, 2017). One study found that there is not a lack of caring from nursing staff, but instead, outside pressures driven by political and economic agendas that interfere with the ability to care (Bray et
Hawke-Eder (2017) believed that unsupportive environments for nurses lead to a psychological withdrawal from the job, which leads to the attitudes of ‘noncaring’ and poor quality of overall care of patients. She called for a directive towards creating caring environments where nursing leadership role model caring behaviors and attributes. She believed caring environments would have a major impact on fostering caring abilities of nurses.

One study by Khouri (2011) cited the high expectations of nurses and the inconsistencies new graduate nurses often face as one reason for a loss of caring. She also explained that nurses are in a constant struggle between the caring model of nursing and the realities of the biomedical model that consumes their practice. Khouri (2011) believed that resolution for these issues would come through connecting back with the foundational principles of nursing. Kosowski (1995) agreed with other researchers that the harsh social, political, and technological demands placed on the profession of nursing is creating an environment of non-caring. She believed that nurse educators must deliver knowledge on human caring behaviors in both the classroom and clinical settings.

Wood (2014) also described the shock nursing students face as they enter the workforce. Many are overwhelmed by their expectations, while also feeling a lack of support from the profession, and disillusioned by their ideals. The author claimed that students should be recruited with realistic expectations of what the profession entails. Horsburgh and Ross (2013) also describe the stressful period of transition from university to practice nurses encounter. Staff nurses feel overwhelmed at their new responsibilities, expectations of immediate competence, and lack of support from their new employers. Horsburgh and Ross (2013) stated that there are implications for nursing education to prepare students for the reality of professional practice.
Moyano (2015) stated nursing education should teach technical aspects of the profession, while also providing students with tools to deal with the ethical dilemmas that must be dealt with daily. There are a multitude of ethical problems and dilemmas that arise in the nursing profession, and there are no books or algorithms to quickly solve the problem. It is the nurses’ responsibility to recognize these issues and to develop ways to solve the dilemmas without personal bias. Moyano (2015) proposed the ethics of care be utilized in the profession to answer the question of what should the nature of the relationship be between and nurse and patient?

Hawke-Eder (2017) also argued that modern-day nursing needs a balance of knowledge, technology and compassion to address the ever-changing challenges of the healthcare crisis. There must be a distinction between teaching nursing students how to deliver compassionate care and how to teach a student to assimilate caring attributes into his or her daily practice. This concept; however, raised a concern on the entire concept of care and caring and if it can be taught (Hawke-Eder, 2017).

Ma et al. (2013) found a decrease in caring abilities of nursing students due to the amount of stressors in the clinical setting. The researchers developed a two-phase descriptive study utilizing the Caring Abilities Inventory (CAI) and focus group interviews as a mixed methods approach. The aim of the study was to provide insight into the caring abilities of baccalaureate nursing students and how the caring abilities changed in regards to practice in the clinical environment. The results demonstrated that students scored lower on caring ability in the clinical courses than those students in the pre-clinical stage (p=.001).

Ma et al. (2013) proposed several reasons for the decrease in caring ability in the clinically involved students. One reason was the lack of empathy due to stressors, fear of making mistakes, increased workload and responsibilities, and the technology-driven environment. In
addition, the authors noted that students were not prepared for the ethical and moral dilemmas that arose in clinical situations. Through the qualitative phase, the researchers were able to gain rich descriptions of the unrealistic expectations that led to a decreased caring ability. Students described shock as they became aware of the inconsistency between the real world of nursing and the idealized hopes of caring for patients that they once held.

It is interesting to note the causes of the lack of empathy from the study’s participants. Fear, increased responsibilities, technology constraints, and large workloads all left little time for nurses to spend caring for the patients. However, the clinical setting was where students should be given the time to learn in a supportive environment that fosters patient interactions and learning. The results of the Ma et al. (2013) study ultimately demonstrated the importance of a critical practice learning environment, caring and effective instructors or facilitators, and encouraging a realistic view into the profession of nursing.

Examining this study through the lens of symbolic interactionism demonstrates the interactions within the clinical setting ultimately changed the ways in which the participants viewed his or her ability to care. It would be noteworthy to gain an insight into how the caring abilities changed. It is challenging to only view one aspect of caring, as the term is so multifaceted. The authors noted that the students’ caring abilities did decrease, but it would be interesting to note if the technical and professional aspect of caring actually increased through the interactions with patients and staff members within the hospital setting.

**Caring Dimensions**

The professionalism shift in nursing had led some theorists to question if traditional caring qualities are being exchanged for scientific and technological caring. Many patients may perceive this type of professional caring as just ‘doing the tasks’ and describe it as ‘noncaring’
(Hawke-Eder, 2017). Other theorists have noted the importance of establishing professional and meaningful relationships with patients (Austgard, 2008; Duffy, 2003; Noddings, 2003; Martinsen, 2000; Sokola, 2013). Specialized knowledge and human interaction is a key component of nursing that sets the profession apart from other health related fields. Austgard (2008) suggested the meaning and definition of care must come from a superordinate level that can incorporate all aspects of care and discern care from non-care. In nursing, listening to and valuing the beliefs of the patient is the core concept behind the ethics of caring. However, patients still need the specialized skills and knowledge that only nurses can provide. This demonstrates the need for not only compassionate care, but also for knowledgeable and technical care.

The shift in nursing from a hospital-based curriculum to an academic setting has left some scholars believing that new graduate nurses are ineffective at performing in multiple dimensions of caring (Hawke-Eder, 2017). Moyano (2015) suggested professional caring requires both the technical and human dimensions. He suggested caring for someone is impossible utilizing a single dimension, therefore, making it impractical to measure care in a strict way. Moyano (2015) believed the act of caring in nursing included more of the technical tasks, or those completed to meet the physical needs of the patient. These tasks help identity and establish relationships between the nurse and patients. He also referred to the human aspect of caring as the transcendental, or spiritual, aspect, which is an expression and difficult to quantify.

Watson, Deary, and Lea (1999a) found that there has been some success in exploring the underlying dimensions of caring. Caring can be considered to have at least two dimensions described as the physical and emotional labors of caring. These can also be described as the instrumental and expressive elements of caring. Watson and Lea (1997) created the Caring
Dimensions Inventory in response to a lack of quantitative tools that explored how nurses perceived care. The tool consists of 25 operationalized statements of nursing actions that were designed to gain an understanding of the dimensions of caring, more specifically, what constitutes care. Exploring caring through the CDI, Akansel, Watson, Aydin, and O’zdemir (2012) demonstrated that nurses conceptualize caring in nursing as having both psychosocial and professional/technical. The professional/technical dimension includes the physical acts that demonstrate caring, such as taking vital signs and administering medications. The psychosocial dimension includes listening to and being with a patient (Watson, Deary, & Lea, 1999). The dimensions can be broken down further to technical and non-technical components.

Omari et al. (2013) also distinguished between two components of caring behaviors. While studies have shown that one dimension is not more important than the other, it is important for nurses to understand each of these dimensions and to recognize the caring needs of patients to ensure the delivery of patient-centered care. The first, instrumental behaviors, encompasses technical and physical behaviors. With the technical dimension, nurses demonstrate caring by applying critical thinking skills and using knowledge and understanding to seek the best practice. The second, expressive behaviors, includes the emotional and psychosocial elements of caring. It is during nursing school courses that students are taught technical and physical behaviors. It is during the clinical component of nursing school that students are able to engage with actual patients and begin to develop expressive behaviors that demonstrate caring. The authors proposed that it is important for nurses to distinguish between the caring dimensions to ensure a better caring experience for patients, while also lending to a sense of accomplishment for acknowledging the patient’s holistic needs (Omari et al., 2013).
Rego et al. (2010) also believed in understanding caring dimensions as a way to increase professional caring attributes. The explicit need of patients to be cared for, not just satisfied, demonstrates the need for a professional nurse that displays both instrumental and expressive care. One study by Kerfoot (1996) found that patients received excellent technical care, but were unsatisfied with their overall care if their emotional needs had not been met appropriately. Professional caring must encompass both technical and emotional behaviors.

Omari et al. (2013) studied nurses’ perceptions of caring behaviors using another quantitative data collection tool, the Caring Behaviors Assessment (CBA). The CBA looks at caring behaviors, as perceived and displayed by the nurse. The researchers found that nurses in Jordan perceived cognitive aspects of care, particularly teaching behaviors, to be the most important while caring for individuals. The nurses also believed the psychological aspect of caring to be very important, such as listening to the needs of the patients and treating patients with respect. Interestingly, the nurses did not place instrumental behaviors, such as technical skills, in the top 10 most important aspects of caring.

Khademian and Vizeshfar (2007) studied nursing students’ perceptions on caring behaviors through the use of an adapted form of the Caring Assessment Questionnaire. Students were asked to respond to 55 caring behaviors listed on a 5-point Likert scale. Ninety-nine nursing students responded to the questionnaire, which was then analyzed using descriptive statistics. The results showed that student perceived practical behaviors demonstrate more caring on the part of the nurse than emotional behaviors. The authors stated that the study’s findings are closely related to a previous study where nursing students described caring in nursing as manual labor, while the study contrasted to other studies where students find emotional behaviors demonstrated more caring than the physical acts.
There is no congruency on how students perceive the delivery of care while in nursing school. Studies have shown that students perceive care as more practical behaviors, involving professional knowledge and skills that lend itself to healing the patient physically, while others perceive caring for the emotional aspects aid in creating the best outcomes for patients. Just like the varying definitions of caring suggests, those in the nursing profession tend to disagree on what caring is and what caring should be within the context of patient care.

**Caring in Nursing Education**

Many scholars, including Noddings, believe that caring can be taught, but this concept has not lent itself to strong empirical validation. Lee-Hsieh et al. (2004) also noted that a caring work and educational environment is enough to teach caring ethics to students, while Yang and Lu (1998) argued that teaching the ethics of care only increased nurses’ knowledge of care, not their actual caring behaviors. Sargent (2012) stated that caring is the foundational essence and central focus for nursing. It is fundamentally woven into everyday practice, yet there is no evidence-based design to teach caring ethics to nursing students (Porr & Egan, 2013).

Over twenty years ago, Higgins (1996) proposed that nursing education held the key to a caring and compassionate practicing nurse. She posited that caring outcomes relied on a caring teaching and learning process. In addition, Higgins believed that there must be a transformation in education to develop well-rounded individuals to enter the caring profession. She also believed students learn how to care professionally in an environment that is caring, and students learn to care through role modeling caring behaviors (Higgins, 1996).

In the last twenty years since this research, there has been variety of studies that have explored how caring abilities and behaviors are affected by nursing education. It is interesting to
note the varying findings of each study. Some studies showed that caring attributes increased during the nursing curriculum, while others demonstrated a decrease.

In a longitudinal study by Watson, Deary, and Lea (1999b), the researchers investigated changes in caring perceptions of students after 12 months in a nursing program. The Caring Dimensions Inventory (CDI) and the Nursing Dimensions Inventory (NDI) were utilized as the tools to understand caring perceptions of students in this study. One hundred and sixty-eight students were initially surveyed upon admission into a nursing program, and 124 students were evaluated upon one year of study. The study showed there was actually a decrease in caring of the students after 12 months in the nursing program. The results demonstrated that many students lost idealism related to nursing duties.

A year later, a longitudinal study by Simmons and Cavanaugh (2000) revealed that nurses’ caring ability significantly increased post-graduation and entry into nursing practice. Both the Caring Ability Inventory and the Parental Bonding Instruments were used to survey female graduates three years following the initial phase-one survey that was conducted during nursing school. The results show that caring ability increased after graduation (P<.001); however, the parental bonding scores did not change. There was a positive correlation between the caring abilities scores of the students while in school and post-graduation (r = .58, P < .001). The caring climate of the nursing schools attended by the participants was factored into the results and showed a strong predictor of caring ability scores (r=.17, P<.05). The findings suggest that caring abilities as a student can further develop in practice, and nursing schools’ caring environments greatly influences the caring abilities of the students well into professional practice.
In 2009, Murphy, Jones, Edwards, James, and Mayer designed a quantitative single cross section survey to determine how caring behaviors change throughout a nursing program in the United Kingdom. The sample groups included 80 first-year students and 94 third-year students, who were both given a caring behaviors inventory (CBI) questionnaire. The results showed a statistically significant difference in caring behaviors of the two sample groups (p=0.038), with the third-year students scoring less than the first-year students. The researchers attributed much of the decline in caring behaviors during nursing school to idealism. They proposed that students entering nursing programs are more idealistic with their approach to caring for patients, but the realities of nursing cause a decrease in caring behaviors. They also suggested the effects of socialization into the profession of nursing may also trigger a nursing student to devalue caring (Murphy et al., 2009).

Sokola’s (2013) study on the caring abilities of nursing students has also added information on caring ethics education. The study showed a weak, but significant relationship between caring ability and caring behaviors of first semester students. Sokola also found that higher scores of caring ability are associated with higher scores of professional caring behaviors among first semester students. In addition, there was a positive relationship between fourth semester students’ caring competency; however, the researcher was not expecting to discover that fourth semester students had lower CAI scores. She attributed this information to the possibility of fourth semester students facing the realities of nursing practice and losing their idealism of caring for patients. One issue that is of concern with the validity of the study is that it is not a linear study. The author studied two different groups of students instead of the same group at two different time periods. This could also be a reason for the differing score.
Ultimately, Sokola suggested further research into discovering factors that influence caring behaviors in nursing students.

Milnar (2010) reviewed the theory of nursing student disillusionment by evaluating the mean scores of the Caring Behaviors Inventory (CBI) between first- and third-year nursing students. The results of the study revealed that the third-year nursing students agreed more with the CBI items than the first-year students. The study confirmed that students learn caring behaviors while they are in the nursing program, while the author suggests clinical work experience is key to the development of these behaviors.

Khouri (2011) looked at how nurses were learning caring behaviors and perceptions during clinical supervision. Khouri believed that all nurses have the responsibility to teach each other and aid in the development of their professional behaviors. The pre-test, post-test study design used the CDI, Nursing Students Attitude Observational Checklist, and the Professional Self-Concept of Nurses Instrument to determine the effects of a program on caring behavior and professional self-perception. 50 senior nursing students in Jordan were divided into either an experimental group who received the educational program, or a control group, which did not receive the educational program. The results immediately following the program, and three months post-program demonstrated that the educational program increased the students’ knowledge and understanding of caring concepts (p<0.001), improved self-perceptions (p<0.000), and a better approach to care within the clinical setting (p<0.000). The study demonstrated the importance of educational programs focusing on caring behaviors. The author recommended the need for nursing education to re-focus attention on caring behaviors in both the classroom and clinical environment by educating students on the foundational caring
behaviors in nursing and by role-modeling and mentoring students to foster caring and professional behaviors in practice.

After reviewing the available literature on caring in nursing education, it is the researcher’s belief that technical attributes can be taught within caring ethics education, but students must be in practice to learn how to care emotionally and psychosocially for a patient. It is through the development of a relationship between the nurse and patient that a student may learn to deliver true empathetic care to another person. This perspective is strongly bound with the theoretical framework of symbolic interactionism.

Through the development of relationships in practice, students can strengthen his or her ability to holistically care for individuals, meaning he or she can care for both the physical and emotional needs of the patient. Caring is so contextually bound, it is difficult to ever describe someone else as ‘noncaring’ because caring is understood differently by each individual. It is also difficult to claim students are less caring before, during, or after a nursing program without understanding that students may have simply changed his or her perception of care and what it means to care for someone.

Caring should be taught through the lens of symbolic interactionism, where meaning, language and thought through interactions create a holistic view of the term. Students need to be taught that caring for someone does not simply mean listening to them and comforting them. It also involves a complex set of knowledge and skills that can be properly implemented to care for the physical needs of the patient, as well.

**Clinical Education Inconsistencies**

Though the benefits to a strong clinical education have been reviewed, it is also important to note the inconsistencies found between nursing programs. There are very few regulations
involving the amount of time spent in clinicals or preceptorships. Spector (2012) noted the inconsistency in nursing regulations of educational programs across the United States. Only seven boards of nursing currently have regulations on the amount of clinical hours for baccalaureate nursing programs. This means that one state may require students to complete 500 hours of clinical education, with no required preceptorship, while another state has no mandatory clinical hour requirements.

The inconsistency in regulations has led nursing accreditation organizations searching for mandates to provide a more consistent approach to nursing education. Organizations such as the Commission on Collegiate Nursing Education (CCNE) and the National League for Nursing Accreditation Commission (NLNAC) have called for student clinical experiences that reflect nationally established patient health and safety goals, by utilizing supervised clinical experiences (NLNAC, 2008; AACN, 2008). In addition, Spector (2012) also notes the need for more clinical hours in nursing programs.

**Preceptorships in Nursing Education**

While classroom and laboratory experiences are important to the education and growth of knowledge in nursing students, clinical education remains the foundation of professional education (Luhanga, Billay, Grundy, Myrick, & Yonge, 2010). Clinical education accounts for a considerable amount of time in nursing education. This time allows students to utilize kinesthetic learning techniques to connect classroom knowledge and clinical skills (Sandvik, Eriksson, & Hilli, 2014). In addition, Courtney-Pratt et al. (2011) stated the importance of clinical education during the undergraduate nursing program cannot be overstated. Clinical education provides students with the ability to gain professional competence, while being supported by registered nurse staff members and educators.
A preceptorship is one form of clinical education that continues to gain popularity in nursing education (Luhanga et al., 2010). Preceptorship programs are much like apprenticeships or mentorship programs, where a student is paired with a trained professional that works in a specific field. The students are able to learn in a safe environment, while being closely supervised by a registered nurse. In traditional clinical experiences, students (usually in groups of eight to ten) are assigned a clinical instructor and clinical agency where learning will take place. The clinical instructor is given the task to ensure each student has meaningful learning opportunities, while juggling the realities of keeping check on multiple students at the same time. Preceptorships offer students the unique experience of working one-on-one with an experienced nurse in the clinical environment, while also being supported by nursing faculty (Luhanga et al., 2010; Udlis, 2006). The nursing faculty are usually not on site, but offer support and monitor student progress through communication with the preceptors. Preceptorships do not take the place of clinicals, but are meant to be used in addition to traditional clinical experiences.

Preceptorship refers to a mentoring relationship between a student and a professional nurse, in which the professional nurse relates information and knowledge to the student to prepare them for their future career (Udlis, 2006). A preceptee is defined as a student in a nursing program who is assigned to work with a registered nurse. A preceptor is a nurse who guides and instructs student nurses in the clinical setting for various amounts of time. The preceptor determines the climate of the overall preceptorship experience for the student (Myrick & Yonge, 2001). The preceptor must provide a mentoring environment that is stimulating and caring to support a professional and authentic relationship to facilitate learning (Myrick & Yonge, 2001; Shepard, 2009).
Goals for the preceptorship experience vary according to varying institutions; however, the overall purpose is to facilitate an easier transition from student to registered nurse (Rose, 2008). Preceptorships are usually completed during the final semester of nursing school. Once all coursework has been completed, or is coming to an end, preceptorships are used to facilitate clinical education, while also allowing students the autonomy to not be constantly supervised by a clinical instructor.

Sandvik et al. (2014) suggested preceptorships are essential to nursing students’ ability to foster critical behaviors and adapt to nursing practice. In addition, the authors also suggest that preceptorships are the time when nursing students can learn different caring dimensions from the mentoring relationship with their preceptor. Mentoring in the clinical setting is one of the most powerful tools for teaching and learning about caring for individuals. Ma et al. (2013) posited that the clinical environment allows students to observe proper behaviors and mannerisms from experienced nursing staff to better improve their own practice. Happell (2009) stated that preceptorships are acknowledged in the literature as a strategy for engaging students in clinical practice, while allowing for confidence building, skill acquisition, and socialization into the profession.

Duteau (2012) stated preceptorships were imperative for the socialization of new graduate nurses into practice. The author noted that a poor clinical transition causes disillusionment by nurses and ultimately led to nurse burnout and a high turnover rate within the profession. It is during the preceptorship that students gain confidence and learn to care for patients within the contexts of nursing practice. Preceptorships have proven to be a valuable addition to nursing education by aiding in a more successful socialization into the profession and
the increase in both clinical confidence and competence (Kelly & McAllister, 2013; Luhango et al., 2010; Rose, 2008).

Wieland et al. (2007) noted that preceptorships are key to providing a transition time for students into the nursing profession. They utilized a triangulated, descriptive study using journal entries of students participating in a three-week pre-graduation preceptorship program. The results demonstrated an expansion of knowledge, responsibility acknowledgement and skill performance, in addition to more independence and an increase in comfort when interacting in the clinical environment. The researchers also agreed that more research needs to be conducted in the area of preceptorships’ use in nursing education, with an emphasis on the length of time for preceptorships, and where and how in the curriculum they are implemented.

In a hermeneutical phenomenology study, Sandvik et al. (2014) utilized focus group interviews of 24 students from three universities in Finland and Sweden to gather information on professional development through preceptorship experiences. The data were analyzed through naïve reading, structural analysis, and comprehensive understanding. The results showed that students want to be cared for during their clinical preceptorship, so that they in turn can learn to care for others. A caring relationship was the foundation for learning and developing in the clinical preceptorship setting (Sandvik et al., 2014).

Natale and Klevay (2013) posited that meaningful experiences were key to developing relationships and connecting with others in nursing. The authors believed that it is essential for educators to create environments that allow students to learn from others and to be present in the care. The authors noted that in a study of journal entries of students involved in a practicum experience, the students frequently revealed they could connect what they have learned in the
classroom to the clinical setting environment. This encouraged students to develop nurse-patient caring relationships.

**Preceptor Selection**

There are several challenges that can affect how the student learns within the preceptorship experience. One challenge is the lack of consistency in the experience level of preceptors (Luhanga et al., 2010). Preceptors are expected to bring experience and advanced knowledge of clinical skills to the preceptorship relationship with the student; however, this is not always the case (Wright, 2002). Due to constraints within the hospital, such as increased workload, time constraints and the high turnover rates of nursing staff, preceptors do not always have the experience desired by nurse educators (Duteau, 2012; Udlis, 2006). This leaves preceptors who are selected based on availability and willingness to serve (Altmann, 2006).

Haggerty, Holloway, and Wilson (2012) discussed attributes of preceptors that positively affect student learning, such as educational background, role preparation, positivity, patience, supportiveness and a passion for the precepting role. Each of these factors have been linked to an increase in competence, confidence and critical thinking ability of the nursing student.

Sweet and Broadbent (2017) noted there is little information on the characteristics of preceptors that affect student learning. In their study, Sweet and Broadbent (2017) examined qualities of nurse preceptors that students felt as most beneficial to his or her learning and overall education. The researchers found that students perceived availability and approachability as the most influential characteristics of preceptors to the students’ learning. In addition, Sweet and Broadbent (2017) noted the importance placed on the relational aspect between the facilitator, or preceptor, the student and the organization in which the preceptorship is taking place is on enhancing student learning.
Tang, Chou, and Chiang (2005) used four categories to describe the characteristics of preceptors that students perceived as being most effective at clinical instruction. The characteristics included teaching ability, professional competence, interpersonal relationship and personality characteristics. In this study, students rated interpersonal relations as being the most beneficial characteristic in being an effective teacher and instructor.

Patricia Benner, known for her novice to expert theory in relation to nursing practice, can also relate professional nursing and the notion of care. Benner believed clinical judgment, or the ways in which nurses understand problems and the concerns of patients can only come with practice and expertise in the field of nursing. Benner asserted nurses with more experience are more likely to exhibit understanding of the whole person and therefore are able to better care for the individual. She believed that an ethic of care must be learned through practical experiences because they are dependent on ethic conduct in explicit situations (Austgard, 2008).

Grasha (1994) described varying teaching styles than can be adopted by instructors or preceptors. The five positive styles include expert, formal authority, personal model, facilitator and delegator. Figure 1, derived from Grasha (1994), describes each of the teaching styles in detail. These styles are connected to roles, attitudes, behaviors of the instructor, or preceptor. It would be useful to gain an understanding if any single teaching styles would offer a better preceptorship experience. It would also be beneficial to gain an understanding of how these teaching styles can change the ways in which a student understands and delivers care in the hospital setting.
<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expert</td>
<td>Possesses knowledge and expertise that students need. Strives to maintain status as an expert by displaying detailed knowledge and challenging students to enhance their competence. Concerned with transmitting information and ensuring that students are well prepared.</td>
</tr>
<tr>
<td>Formal Authority</td>
<td>Possesses status among students because of knowledge and role as a nurse. Concerned with providing positive/negative feedback, establishing learning goals, expectations, and rules of conduct. Concerned with “correct, acceptable, and standard ways to do things.”</td>
</tr>
<tr>
<td>Personal Mode</td>
<td>Believes in “teaching by example,” establishes a prototype for how to think and behave. Oversees and directs by showing how to do things and encouraging students to observe and then emulate the instructor’s approach</td>
</tr>
<tr>
<td>Facilitator</td>
<td>Emphasizes the personal nature of teacher-student interactions. Guides students by asking questions, exploring options, suggesting alternatives, and encouraging informed decisions. Develop student capacity for independent responsibility. Works as consultant on student projects and provides support and encouragement.</td>
</tr>
<tr>
<td>Delegator</td>
<td>Concerned with developing students’ capacity to function autonomously. Students work independently on projects or as part of autonomous teams. The teacher is available at the request of students as a resource.</td>
</tr>
</tbody>
</table>

*Figure 1*. Five primary teaching styles as proposed by Grasha (1994)

In reviewing the literature, there was little information on preceptorships in nursing education. The research that was discovered focused on determining qualities of preceptors that aided in the best educational outcomes of nursing students. There was no current research on the influence that preceptorships have on the caring attitudes and behaviors of nursing students. As Sandvik et al. (2014) noted, preceptorships can be used effectively to foster caring behaviors by developing and maintaining mentoring relationships between nursing students and preceptors. However, there is no current research on how students’ engagement in relationships with both nurse preceptors and patients during a preceptorship program enhance or diminish caring attributes. There is also no information in the literature concerning the types of clinical units students are placed on and their influence on the caring outcomes of students. It is important to
explore these concepts to provide a broader understanding of what qualities of the preceptorship program alter the ways in which students perceive care.

**Theoretical Framework**

Symbolic interactionism (SI) can be traced back to pragmatism, where it is the belief that humans learn through practice within contextual experiences (Carlson, 2012). George Herbert Mead’s philosophical ideas provided the foundation for SI (Burbank & Martins, 2009; Vejar, 2009). He believed that communication and interactions with others created meaning and ultimately self-discovery (Vejar, 2009). The term symbolic interactionism was coined by one of Mead’s students at the University of Chicago, Herbert Blumer, to describe how humans create meaning within social contexts and interactions.

The core principles of SI are meaning, language, and thought. It is the belief of SI that meaning is given through interpretation. Language is the means in which humans create meaning, and through thinking and reflecting on these experiences, meaning is created. In addition, a central idea of SI lies in the self that is created. Self continually evolves out of the interactions within social contexts (Carlson, 2012). Humans and society are considered undividable because it is through social interactions that humans find meaning. Blumer (1986) developed the following three SI core principles: 1) humans act on the meaning things hold; 2) meaning is derived from social interactions; and 3) meaning is modified through interpretation and reflection on those interactions.

Symbolic Interactionism has been applied to many issues in healthcare, such as aging (Rozario & Derienzis, 2009), relationships between nurses and patients (Lowenberg, 2003), and understanding how mental illness affects families (Saunders, 1997); however, it is a theory that is widely used in qualitative research, particularly in the field of sociology (Burbank & Martins,
2009; Ulmer & Wilson, 2003). Ulmer and Wilson (2003) argued that symbolic interactionism has a place within quantitative research, particularly when looking at relationships and comparison studies. They also argue that utilizing symbolic interactionism in quantitative research will enable researchers to address more topics and provide a different lens to view current data.

Jones and Somekh (2006) proposed that behavior is constructed through interactions with both individuals and groups of people. Much of this interaction becomes routine, or as the authors propose, an action-response operation. Smit and Fritz (2008) utilized the core principles of SI to develop a diagram of teacher identity following an ethnographic inquiry into teacher narratives reflecting educational change in South African schools. They proposed that identity is developed through the use of situational, social, and personal narratives. Smit and Fritz (2008) gave the following explanation of each construct:

Situational identity emerges from collective behavior and meaning that is derived during face-to-face interactions and communication with people. For the purpose of this study, this situational narrative was identified through nursing student communication with the preceptors. The study examined how personal attributes of the nurse preceptors changed the situational identity of the nursing student.

Social identity emerges through socially constructed categories of people or the position within a social structure, such as the clinical environment. The identity will remain intact as long as the social structure and relationships remain stable. This study examined the clinical, or precepting environment, as the social narrative. The environment included both the hospital and the particular unit in which the student is precepting.
Personal identity is constructed through the uniqueness of an individual. Personal identity is developed through individual narratives. Persons may choose to select or remove information that builds his or her identity depending on the audience. For the present study, personal narrative was identified as the individual students’ perceptions of care.

Smit and Fritz (2008) proposed that if thoughts can change the symbols in which a person encounters, and language exposed thoughts and provided meaning that is negotiated through the symbols in which the person acts, then greater insights and understandings into the thoughts behind the personal, situational and social identity could result in a behavior change. If this notion is modified to fit within the context of the present study, it is proposed that through symbolic interactionism, students’ perceptions of care may be modified through the interactions within social and situational narratives during the preceptorship experience. Figure 2 is a derivative of Smit and Fritz’s (2008) model that has been modified to include the context for the present study. This model was used throughout the data analysis to provide a lens to view how personal identities of caring were altered through the social and situational interactions after a preceptorship experience.
In summary, SI can provide a framework for this study because it will allow a view of how students create meaning regarding caring perceptions within the social contexts of the preceptorship program. It is the idea of SI that humans find meaning when they are in practice and within the social contexts of practice. Preceptorships, as part of the nursing curriculum, give students the opportunity to practice what they have learned within the institution and apply theory to practice. It is during this time, caring ethics can be given meaning and truly understood by the nursing student through building relationships and communicating within the context of the preceptorship. Caring is understood within the context of relationships for individuals. Many understand caring aspects from the ways in which they have been cared for in the past or how they prefer to be cared for in the future. Through the utilization of symbolic interactionism as a theoretical framework, this study examined how students perceived caring after time spent in communication, interaction, and within relationships in the preceptorship experience.
Summary and Gaps in the Literature

While research on the topic of caring in nursing is vast among the literature, there are incongruences concerning the best methods to teach caring ethics in nursing education. There is information in the literature that focuses on teaching the psychomotor aspect of nursing, but ways to teach the affective domain are often not explored. Caring, as the foundational principle in nursing, should have a clear and specific way to be taught in the classroom. Instead, there are many inconsistencies that lead to confusion in the literature.

In addition, there is a gap in the research concerning the topic of preceptorships and their place in nursing education and the effects preceptorships have on caring attitudes and behaviors in students. Udlis (2006) also noted the lack of literature on the effectiveness of nursing preceptorships. More inquiry could offer important information on the knowledge and skills that can be best discovered during a preceptorship experience. In addition, the few research studies that do exist demonstrated a lack of consistency in the findings.

Preceptorships, as a type of work-based learning, are an opportunity for students to gain knowledge and skills, while also transitioning into practice. The goal of this study is to gain information regarding the senior preceptorship and the benefits of teaching caring ethics through interaction in practice. This information will aid in filling the gap on methods of teaching caring ethics to students, in addition to adding literature on the benefits of preceptorships within the nursing education curriculum.

There is also a noted gap in the literature concerning the characteristics of preceptors and the preceptorship location (Udlis, 2006). Characteristics of the nurse preceptor such as primary teaching style and number of years practicing as a Registered Nurse, in addition to descriptions of the type of clinical units where the students are precepting could lend itself to rich descriptions
of how these characteristics correlate with study outcomes. This research may also aid in advising preceptor selection processes and defining characteristics that correlate with successful preceptorship program outcomes.
CHAPTER III:

METHODOLOGY

Introduction

This quantitative study explored how time spent in preceptorship changed the caring perceptions of students prior to graduation from one baccalaureate nursing program. The study also explored the relationship between the years of experience of a registered nurse preceptor and the perception of caring of senior-level baccalaureate nursing students. In addition, the study compared characteristics of the preceptorship such as the type of clinical unit and the primary teaching style, as perceived by the student, of the nurse preceptor, to the senior-level nursing students’ perception of caring. Participants were recruited through convenience sampling of senior-level nursing students from one baccalaureate degree nursing program in the southeastern United States. While, a descriptive design allowed the researcher to gain an understanding of the characteristics of the population being studied, in addition to aiding in the comparison of data (Williams, 2007), the correlation component was used for exploring the relationship among variables (Creswell, 2005).

Purpose of the Study

The purpose of this study was fourfold: 1) to determine if there was a relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience; 2) to determine how senior-level baccalaureate nursing students’ perception of caring compared among the primary teaching styles of registered nurse preceptors after a 225-hour preceptorship
experience; 3) to determine how senior-level baccalaureate nursing students’ perception of caring compared among varying clinical units after a 225-hour preceptorship experience; and 4) to determine if there was a difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience. Overall, the purpose of the study sought to compare what, if any, qualities of a preceptorship experience to the ways in which baccalaureate nursing students perceived caring.

**Research Questions**

The research questions for this study were as follows:

1. What is the relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience;

2. How do senior-level baccalaureate nursing students’ perception of caring compare among primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience;

3. How do senior-level baccalaureate nursing students’ perception of caring compare among varying clinical units after a 225-hour preceptorship experience; and

4. What is the difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience?
Theoretical Framework

The theoretical framework of symbolic interactionism (SI) was used to guide both the data collection and the data interpretation for the study. The framework provided a lens to explore the relationships between nursing students’ perception of care and the characteristics of a senior-level preceptorship experience, including varying types of clinical units and time spent with preceptors with varying teaching styles and years of experience as a registered nurse. During the data collection phase, the CDI-25 was utilized to gather information concerning the caring perceptions of nursing students before and after a preceptorship experience. The preceptorship experience was chosen as it offers an opportunity for students to closely interact with patients and peers in a professional setting. The instrument was chosen to gather information on how caring perceptions change in relation to time spent communicating and within a relationship with both nurse preceptors and patients. Finally, SI offered a unique perspective to interpret the data collected in the study by closely examining how students interacting within a new social context changed their beliefs and attitudes on caring. Through the utilization of symbolic interactionism as a theoretical framework, this study examined how students perceived caring after time spent in communication, interaction, and within relationships in the preceptorship experience.

Participants

Participants were recruited through convenience sampling of nursing students from one baccalaureate degree nursing program. The university chosen for this study was a public, research-focused institution located in the southeastern United States. The program had a requirement of 225 hours of preceptorship experience. Access and permission were obtained through connections with faculty and administrators. In addition, the researcher received
Institutional Review Board (I.R.B.) approval at The University of Alabama. The researcher had no academic contact with or authority over the students participating in the study. Inclusion criteria for participation in this study included being between 19 and 60 years of age and current enrollment in the final semester of nursing school. In addition, students were excluded if they had previously received a failing grade in the preceptorship course.

Preceptorship Program Descriptions

The preceptorship program in this study provided students with the opportunity to work one-on-one with a registered nurse in the hospital setting, while also being supervised by a clinical faculty member. The program required a 225-hour preceptorship that started after completing and passing a final semester critical care course. Once the six-week course was completed, the students were able to begin their preceptorship, while only being enrolled in one other course that met weekly.

The nursing program allowed students to choose his or her top three preferences of hospitals and units, but ultimately, the course leader of the preceptorship course determined the precepting location for each individual student. The students were given the option to choose a variety of geographical locations and units in the specific hospitals in which contracts have been formed with the institution. The majority of hospital were located within the southeast United States. The units included acute care medical units, including women and children’s services, and surgical services. The model of nursing care varied from unit to unit, which means the students were exposed to varying models of nursing care.

The students were assigned one preceptor to complete the total required 225 hours. The students were allowed to use one other registered nurse as a back-up preceptor during one shift. This allows the students the flexibility to change one shift if needed. In addition, the students
were also given the option to exchange a total of twenty-four hours of clinical preceptorship for Alabama Board of Nursing approved nursing continuing-education hours or professional nursing organization meeting attendance as approved by course faculty. As a course requirement, the students were asked to complete clinical logs with specific questions pertaining to patient care each week, while also tracking the completed hours. The nursing students were also responsible for having the nurse preceptor complete an evaluation at approximately 100 hours and at the completion of 225-hours of preceptorship.

**Data Collection**

After I.R.B. approval, data collection took place through a self-administered online survey using Qualtrics, a web-based survey application. Utilizing Qualtrics helped promote anonymity, cost efficiency, convenience for the participants and researcher, and overall quality of data collection and interpretation, by reducing potential errors. Prior to the beginning of the preceptorship experience, the researcher attended an on campus class session to introduce the research project to the students. The researcher introduced the purpose of the study and the steps to participate in the study.

Following the on campus session, students were sent an email with a link to Qualtrics. In Qualtrics, the researcher provided a written informed consent that detailed the purpose of the study, information on the researcher, what was expected of them as a participant, the risks and benefits of the study to the participant and an estimated time commitment. In addition, the written informed consent stated that the participant may choose to withdraw from the study at any point without penalty. The participants were required to sign the consent via the online Qualtrics system prior to beginning the study. After selecting agree, the participants were taken to the beginning of the questionnaire.
Once informed consent was obtained, the participant was asked to complete the first round of data collection, which included an instrument comprised of a demographic information section and the CDI-25. The demographic section asked students to respond to questions such as their age, gender, and prior educational experiences and prior work experiences for the purpose of collecting descriptive statistics on the participants. Participants were ensured that Qualtrics did not provide the researcher with an IP address of the participants; however, students were asked to use the last four digits of their student identification number when accessing each round of CDI-25 data collection. This allowed the researcher to maintain consistency in the data collection. In addition, participants were asked to avoid giving any identifying information when completing the background survey.

After completion of all 225-hours of the preceptorship, a second link to the CDI-25 was sent to the participating students for completion via Qualtrics. In addition to completing the CDI-25, participants were asked to complete a short questionnaire regarding the descriptive characteristics of the preceptor and precepting environment including the type of unit the student was placed on, the years of experience as a R.N. of the nursing preceptor, and the teaching style that best described the preceptor.

**Data Collection Instrument**

The CDI-25 was developed by Watson and Lea (1997) to gather information concerning nurses’ perception of caring. The tool consists of 25 operationalized statements of nursing actions that were designed to gain an understanding of the dimensions of caring, more specifically, what constitutes care. The responses to the prompt question of *do you consider the following aspects of your nursing practice to be caring* are given on a 5-point Likert scale ranging from 5= strongly agree to 1= strongly disagree. Scoring for the tool can range from 25-
Mokken scaling was used in developing and validating the psychometric tool and is a way to determine unidimensional scaling. The Mokken scaling procedure scales items to create a positively scored list of items and organizes the items into a hierarchy (McCance et al., 2009). With Mokken scaling, the higher the score on the CDI-25 demonstrates nurses’ belief that professional and technical aspects of nursing are perceived as more caring, while lower scores indicate psychosocial aspects are perceived as more caring (Watson & Lea, 1998). Using Chronbach’s alpha, reliability of the 25 questions demonstrated a high degree of internal consistency at .91 (Watson & Lea, 1997). In addition, the validity of the tool has been demonstrated its ability to discriminate between male and female nurses and between older and younger nurses (Watson & Lea 1997). Exploratory factor analysis revealed a general underlying single dimension to caring and at least two other dimensions, which are the psychosocial and the professional/technical dimensions. The professional/technical dimension includes the physical acts that demonstrate caring, such as taking vital signs and administering medications. The psychosocial dimension includes listening to and being with a patient. In addition, there was also evidence for further dimensions of altruism, putting the needs of a patient before your own, and involvement, sharing personal issues with patients (Watson, Deary, & Lea, 1999). The instrument does not measure caring, instead, it measures the dimensions in which nurses perceive caring (Akansel et al., 2012). Watson and Lea (1997) describe the CDI as a research instrument and not as a score that indicates the extent to which a nurse cares.

The present study examined the CDI-25 from a multidimensional scale. Instead of using Mokken scaling as a way to score the CDI-25, the researcher used the underlying scores of the CDI-25 as a surrogate for caring and that score was used as a dependent value on the interval level. Raw scores on the CDI-25 were calculated for each participant. The pre-preceptorship
scores were then compared to the post-preceptorship scores. The higher the score on the CDI indicates the participants’ belief that professional and technical aspects of nursing are perceived as more caring, while lower scores indicate psychosocial aspects are perceived as more caring.

The CDI-25 was chosen as an instrument for this study in order to gain an understanding of how nursing students perceive caring after the senior-level preceptorship experience. The tool gave the researcher the opportunity to gain information regarding which caring dimensions are strengthened or weakened after participating in the preceptorship experience. In addition, the tool also gave the researcher an opportunity to examine how different characteristics of the preceptorship experience individually change the ways in which a nursing student perceives care.

Data Analysis

Once the data collection was complete, Qualtrics was used to input the data into SPSS software, which was then stored on a password protected personal computer. The data were analyzed using descriptive statistics, in addition to Spearman’s correlation coefficient and t-test. The data from Qualtrics were stored on a password-protected computer and will be deleted within five years of study completion.

Table 1 explains how the methodology for this study addressed the research questions.
Table 1

*Data Collection and Analysis Process*

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Theoretical Framework</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience?</td>
<td>This question sought to explore how the students’ situational identity emerges during face-to-face communication with registered nurse preceptors in the clinical environment, and if years of experience practicing as an RN changes students’ perception of care. The data were interpreted through the lens of symbolic interactionism to evaluate how nursing students’ view of caring dimensions changed within the contexts of relationships during the preceptorship experience.</td>
<td>Data were collected before and after the preceptorship experience using the CDI-25, which was used to determine the nursing students’ perception of care. The data were analyzed using descriptive statistics and Spearman’s correlation coefficient to determine if there was a relationship between the years of experience of the RN preceptor and the perception of caring (students’ CDI-25 scores) after 225-hours of preceptorship.</td>
</tr>
<tr>
<td>2. How do senior-level baccalaureate nursing students’ perception of caring compare among primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience?</td>
<td>This question sought to explore how the students’ situational identity emerged during face-to-face communication with registered nurse preceptors in the clinical environment, and how the primary teaching style, as perceived by the student, compared to students’ perception of care. The data were interpreted through the lens of symbolic interactionism to evaluate if nursing students’ view of caring dimensions changed within the contexts of relationships during the preceptorship experience.</td>
<td>Data were collected before and after the preceptorship experience using the CDI-25 and the Preceptorship Experience Questionnaire, which asked students to choose the primary teaching style of his or her nurse preceptor. The data were analyzed using descriptive statistics.</td>
</tr>
<tr>
<td>Research Question</td>
<td>Theoretical Framework</td>
<td>Methodology</td>
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<tr>
<td>3. How do senior-level baccalaureate nursing students’ perception of caring compare among varying clinical units after a 225-hour preceptorship experience?</td>
<td>This question sought to explore how the students’ social identity emerged during time spent in the precepting clinical environment, and how the particular clinical units compared to the caring perceptions of the nursing students.</td>
<td>Data were collected before and after the preceptorship experience using the Caring Dimensions Inventory, which measures nurses’ perception of care. The data were analyzed using descriptive statistics.</td>
</tr>
<tr>
<td></td>
<td>The data were interpreted through the lens of symbolic interactionism to evaluate if nursing students’ view of caring dimensions changed within the environment of the clinical unit during the preceptorship experience.</td>
<td></td>
</tr>
<tr>
<td>4. What is the difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience?</td>
<td>This question seeks to explore how the students’ personal identity, as related to caring ethics, emerges during time spent in preceptorship. The data were interpreted through the lens of symbolic interactionism to evaluate if time spent in the preceptorship experience changed how the students perceive care.</td>
<td>Data were collected before and after the preceptorship experience using the Caring Dimensions Inventory, which measures nurses’ perception of care. Data analysis were conducted using descriptive statistics and a paired samples t-test.</td>
</tr>
</tbody>
</table>
Summary

As clinical hours continue to be eliminated due to clinical site constraints and faculty shortages, it is important to gain an understanding of the critical role clinical education plays in the transition of nursing students to practice. Nursing education continues to explore ways to teach caring ethics to students, as more research demonstrates nurses as ‘noncaring’ and uncompasionate (Porr & Egan, 2013). This quantitative study explored how time spent in a preceptorship experience changed how senior-level nursing students perceive caring. In addition, different types of clinical units and preceptors were explored as a means to changing caring perceptions of the students. The results of the study may be utilized to demonstrate the importance of hands-on clinical education in building caring attributes in students, in addition to guiding educators in identifying the best characteristics of the precepting environment that can aid in teaching caring ethics to nursing students.
CHAPTER IV:

RESULTS

Introduction

The purpose of this study was fourfold: 1) to determine if there was a relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience; 2) to determine how senior-level baccalaureate nursing students’ perception of caring compared among the primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience; 3) to determine how senior-level baccalaureate nursing students’ perception of caring compared among varying clinical units after a 225-hour preceptorship experience; and 4) to determine if there was a difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience. Rather than broadly looking at how caring attributes change during an undergraduate nursing program, research was conducted to examine how interactions within a specific clinical experience changed nursing students’ perception of care. Chapter IV is organized around the four research questions (RQs):

1. (RQ1) What is the relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience;
2. (RQ2) How do senior-level baccalaureate nursing students’ perception of caring compare among primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience;

3. (RQ3) How do senior-level baccalaureate nursing students’ perception of caring compare among varying clinical units after a 225-hour preceptorship experience; and

4. (RQ4) What is the difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience?

Caring perceptions were measured using the Caring Dimensions Inventory (CDI-25). A variety of statistical analysis techniques were used (Spearman’s Correlation Coefficient, t-test, and descriptive statistics) to give the best descriptions how nursing students’ perception of care changes in relation to time spent in the preceptorship and varying factors of the preceptorship experience. The present study examined the CDI-25 from a multidimensional scale, where the underlying scores of the CDI-25 were used as a surrogate for caring and that score was used as a dependent value on the interval level. Raw scores on the CDI-25 were calculated for each participant. The higher the score on the CDI indicated the participants’ belief that professional and technical aspects of nursing are perceived as more caring, while lower scores indicate psychosocial aspects, or non-technical aspects, are perceived as more caring. It was the intent to perform regression analysis to determine the relationship among each of these factors and the nursing students’ perception of care, but there was not enough in the sample size to do so in a valid manner. This issue is discussed further in the limitations section.
Demographics

Demographic data are characteristics about the study participants that aid in assessing the generalizability of the results (Gravetter & Wallnau, 2009). Each of the participants was enrolled in the fifth, and final semester of the upper division of a BSN program. The university chosen for this study was a public, research-focused institution located in the southeastern United States. The program required a 225-hour preceptorship that began after completing and passing a final semester critical care course.

Demographic data collected on the participants included age, gender, grade point average (G.P.A.), and work history in a healthcare related field. The recruited sample size was 85 participants, however only 31 completed the entire survey and met the inclusion criteria. As seen in Figure 3, the age of participants ranged from 20 to 50 years and both males and females participated in the study. One participant was in the 19-21 age group (3.2%), 28 participants were in the 22-24 age group (90.3%), one participant was in the 31-40 age group (3.2%), and one participant was in the 41-50 age group (3.2%). There were 26 females (83.9%) and 5 males (16.1%).

Figure 3. Age and gender distributions
The approximate G.P.A. was broken down into categories, as seen in Figure 4. Three participants had a G.P.A. of 3.8-4.0 (9.7%), 19 participants had a G.P.A. of 3.5-3.7 (61.3%), 8 participants had a G.P.A. of 3.1-3.4 (25.8%), and one participant had a G.P.A. of 2.8-3.0 (3.2%).

![G.P.A. Distributions](image)

*Figure 4. G.P.A. Distributions*

The participants were asked if they had prior or current work experience in a health-related field. A total of 6 participants (19.4%) had current work experience, 12 participants (38.7%) had previous work experience, 4 participants (12.9%) had both prior and current experience and a total of 9 participants (29%) had neither current nor past work experience in the healthcare field, as shown in Figure 5.
Research Question 1

What is the relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience?

Descriptive statistics were used to determine the number and percentages of the different categories of years as a R.N. Table 2 outlines the frequencies, where the left column describes the year categories. Descriptive statistics are used to abbreviate a collection of data. The purpose of descriptive statistics is to describe a collection of data without having to look and read the total collection (Lomax & Hahs-Vaughn, 2012).

Figure 5. Work experience in healthcare distributions

![Bar chart showing work experience in healthcare distributions]
Table 2  

*Years of Practice as a Registered Nurse*

<table>
<thead>
<tr>
<th>Years</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>4</td>
<td>12.9</td>
</tr>
<tr>
<td>2-3</td>
<td>10</td>
<td>32.3</td>
</tr>
<tr>
<td>4-5</td>
<td>3</td>
<td>9.7</td>
</tr>
<tr>
<td>6-8</td>
<td>6</td>
<td>19.4</td>
</tr>
<tr>
<td>9-12</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>13-16</td>
<td>3</td>
<td>9.7</td>
</tr>
<tr>
<td>17-21</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>22-29</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>40-49</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Spearman’s correlation coefficient is a statistical measure of the strength of a monotonic relationship between paired data. In a sample, it is denoted by \( r_s \) and the correlation ranges from \(-1.0 < r_s < 1.0\). A negative sign indicates that as the values for one variable increase, the values for the other variable decrease, thereby causing an inverse relationship. A positive score indicates that as one variable value increases, the other variable also increases. Correlation is an effect size whereas the strength of the correlation can be interpreted using the following guide: .00-.19 “very weak”, .20-.39 “weak”, .40-.59 “moderate”, .60-.79 “strong”, .80-1.0 “very strong” (Lomax & Hahs-Vaughn, 2012).

Spearman’s correlation coefficient was computed to determine the relationship between the years of experience of registered nurse preceptors on baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience. The test was conducted using an alpha of .05. The Spearman’s correlation between years of experience as a R.N. and the nursing
student’s perception of caring was -.404, which is interpreted as a negative, moderate effect size and is statistically significant from 0 ($r_s = -.404$, $n = 31$, $p = .024$). Table 3 demonstrates the correlation.

**Table 3**

*Spearman’s rho for Years of Experience and Post-CDI-25 Scores*

<table>
<thead>
<tr>
<th></th>
<th>Years of Experience</th>
<th>CDI-25 Post-score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman’s rho</td>
<td>1.000</td>
<td>-.404*</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.</td>
<td>.024</td>
</tr>
<tr>
<td>n</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>CDI-25 Post Score</td>
<td>-.404*</td>
<td>1.000</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.024</td>
<td>.</td>
</tr>
<tr>
<td>n</td>
<td>31</td>
<td>31</td>
</tr>
</tbody>
</table>

*. Correlation is significant at the 0.05 level (2-tailed).

**Research Question 2**

How do senior-level baccalaureate nursing students’ perception of caring compare among primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience?

Participants were asked to choose which style primarily described his or her preceptors’ primary teaching style. Students were given Figure 1: *Five Primary Teaching Styles* proposed by Grasha (1994) with descriptions of each teaching style. Since the primary teaching style, as defined by the student, is a nominal variable, descriptive statistics were used to analyze this data. The descriptive statistics were computed and are located in Table 4. In reviewing the descriptive statistics, six participants identified his or her nursing preceptor as an expert. The CDI-25 mean score for these participants was 103.67. The standard deviation was 9.18 and the variance was 84.27. The formal authority description was chosen by three participants. The mean score on the
CDI-25 for participants that chose the formal authority description for his or her preceptor was 104.33. The standard deviation was 10.21 and the variance was 104.33. Ten participants identified his or her nursing preceptor as personal mode. The CDI-25 mean score for these participants was 103.5. The standard deviation was 12.02 and the variance was 144.5. A total of eight participants chose the facilitator category. The mean for these participants was 113.5. The standard deviation was 7.67 and the variance was 58.86. Finally, the delegator was chosen by four participants. The mean score on the CDI-25 was 103.25. The standard deviation was 11.295 and the variance was 127.58.

Table 4

*Descriptive Statistics of Nurse Preceptors’ Teaching Styles*

<table>
<thead>
<tr>
<th></th>
<th>1-Expert</th>
<th>2- Formal Authority</th>
<th>3-Personal Mode</th>
<th>4-Facilitator</th>
<th>5-Delegator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>19.4%</td>
<td>9.7%</td>
<td>32.2%</td>
<td>25.8%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Mean</td>
<td>103.67</td>
<td>104.33</td>
<td>103.5</td>
<td>112.00</td>
<td>103.25</td>
</tr>
<tr>
<td>Std. Error of Mean</td>
<td>3.75</td>
<td>5.90</td>
<td>3.80</td>
<td>2.71</td>
<td>5.65</td>
</tr>
<tr>
<td>Median</td>
<td>104.50</td>
<td>100.00</td>
<td>105.00</td>
<td>113.50</td>
<td>103.00</td>
</tr>
<tr>
<td>Mode</td>
<td>88.00</td>
<td>97.00</td>
<td>88.00</td>
<td>104.00</td>
<td>93.00</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>9.18</td>
<td>10.21</td>
<td>12.02</td>
<td>7.67</td>
<td>11.30</td>
</tr>
<tr>
<td>Variance</td>
<td>84.27</td>
<td>104.33</td>
<td>144.50</td>
<td>58.86</td>
<td>127.58</td>
</tr>
<tr>
<td>Range</td>
<td>26.00</td>
<td>19.00</td>
<td>37.00</td>
<td>21.00</td>
<td>21.00</td>
</tr>
<tr>
<td>Minimum</td>
<td>88.00</td>
<td>97.00</td>
<td>88.00</td>
<td>103.00</td>
<td>93.00</td>
</tr>
<tr>
<td>Maximum</td>
<td>114.00</td>
<td>116.00</td>
<td>125.00</td>
<td>124.00</td>
<td>114.00</td>
</tr>
<tr>
<td>Sum</td>
<td>622.00</td>
<td>313.00</td>
<td>1035.00</td>
<td>896.00</td>
<td>413.00</td>
</tr>
</tbody>
</table>
Research Question 3

How do senior-level baccalaureate nursing students’ perception of caring compare among varying clinical units after a 225-hour preceptorship experience?

To analyze this question, the units were broken into multiple categories. Participants were asked to choose the location of his or her preceptorship from the list of the following units: Adult medical-surgical (Adult M/S), adult intensive care unit (Adult I.C.U.), operating room, emergency department (E.D.), labor and delivery (L&D), post-partum women’s unit (Post-partum), neonatal intensive care unit (N.I.C.U.), pediatric intensive care unit, pediatric medical-surgical units (Ped M/S), adult psychiatric unit, pediatric psychiatric unit, or other. The nominal variables, which are considered categorical, or qualitative in nature, were analyzed using descriptive statistics. As shown in Table 5, seven of the twelve possible unit selections were chosen by the participants.

Post-preceptorship scores were grouped into the unit categories selected by the participants and the data were analyzed using descriptive statistics. The post-preceptorship CDI-25 scores ranged from 88 to 125 across all of the units. One participant chose the adult medical-surgical unit as the unit that most related to his or her preceptorship location. The individual scored 116 on the CDI-25. 11 participant selected the adult intensive care unit as the unit that most related to his or her preceptorship location. Out of those participants, the mean score on the CDI-25 was 104.18. The scores ranged from a low score of 88 to a high score of 124. The standard deviation was 10.87 and variance was 118.164. The emergency department was chosen by five participants. The CDI-25 scores ranged from 103 to 125, with a mean score of 110.8. The standard deviation was 8.786 and the variance was 77.2. Five participants chose the labor and delivery unit. These scores ranged from 94 to 117, with the mean of 107.4. The standard
deviation was 9.889 and the variance was 97.8. Five participants also chose the neonatal intensive care unit, where the scores ranged from 89 to 114 with a mean of 102.8. The standard deviation was 11.606 and the variance was 134.7. The pediatric medical-surgical unit was selected by three participants. These participants scored between 90 and 117 on the CDI-25 post-preceptorship survey, with a mean total of 104. The standard deviation was 13.527 and the variance was 183. One student chose the “other” category and did not give a description of the type of unit he or she was placed on for the preceptorship. The student scored 100 on the CDI-25.

Table 5

Descriptive Statistics for Precepting Units

<table>
<thead>
<tr>
<th></th>
<th>Adult M/S</th>
<th>Adult I.C.U.</th>
<th>E.D.</th>
<th>L&amp;D</th>
<th>N.I.C.U.</th>
<th>Ped M/S</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
<td>1</td>
<td>11</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td>3.3%</td>
<td>35.5%</td>
<td>16.1%</td>
<td>16.1%</td>
<td>16.1%</td>
<td>9.6%</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>116.00</td>
<td>104.18</td>
<td>110.80</td>
<td>107.40</td>
<td>102.80</td>
<td>104.00</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>116.00</td>
<td>104.00</td>
<td>111.00</td>
<td>112.00</td>
<td>104.00</td>
<td>105.00</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Mode</strong></td>
<td>116.00</td>
<td>88.00</td>
<td>111.00</td>
<td>94.00</td>
<td>114.00</td>
<td>90.00</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>.00</td>
<td>36.00</td>
<td>22.00</td>
<td>23.00</td>
<td>25.00</td>
<td>27.00</td>
<td>.00</td>
</tr>
<tr>
<td><strong>Minimum</strong></td>
<td>116.00</td>
<td>88.00</td>
<td>103.00</td>
<td>94.00</td>
<td>89.00</td>
<td>90.00</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>116.00</td>
<td>124.00</td>
<td>125.00</td>
<td>117.00</td>
<td>114.00</td>
<td>117.00</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Sum</strong></td>
<td>116.00</td>
<td>1146.00</td>
<td>554.00</td>
<td>537.00</td>
<td>514.00</td>
<td>312.00</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>10.87</td>
<td>8.79</td>
<td>9.89</td>
<td>11.61</td>
<td>13.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Variance</strong></td>
<td>118.16</td>
<td>77.20</td>
<td>97.80</td>
<td>134.70</td>
<td>183.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Research Question 4

What is the difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience?

A paired sample \( t \)-test was performed at an alpha level of 0.5 to determine the relationship between the amount of hours of preceptorship and senior-level baccalaureate nursing students’ perception of care after a 225-hour preceptorship experience. Dependent \( t \)-test can be used when there are two samples that are dependent, meaning that sample one and sample two have a relationship with each other. The dependent \( t \)-test uses the means, so the dependent variable must be measured at an interval or ratio (Lomax & Hahs-Vaughn, 2012). The hypothesis being tested is denoted by the following formula:

\[
H_0: \mu_{\chi_1} = \mu_{\chi_2} \quad H_A: \mu_{\chi_1} \neq \mu_{\chi_2}
\]

Based on 30 participants \((n = 30)\), descriptive statistics showed the mean pre-score for the CDI-25 was 102.63 and a standard deviation of 11.36. The mean post-score for the CDI-25 was 106.20 and a standard deviation of 10.13. Table 6 shows the mean of the paired samples \( t \)-test was -3.567 and the standard deviation was 12.02. There was not a significant difference in scores of the caring dimensions inventory after the preceptorship experience \((t = -1.625, df = 29, p = .115)\). Additionally, the effect size was computed using the following formula:

\[
\text{Cohen d} = \frac{d}{s_d}
\]

The effect size \( d \) was calculated at 0.33, which is generally interpreted as a small effect (Cohen, 1988).
Table 6

*t-test for Pre- and Post-CDI-25 Scores*

<table>
<thead>
<tr>
<th>Paired Samples Test</th>
<th>Paired Differences</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Deviation</td>
<td>Std. Error</td>
<td>95% Confidence Interval of the Difference</td>
</tr>
<tr>
<td>Pair</td>
<td>PreScoreTotal -</td>
<td>-3.56667</td>
<td>12.02206</td>
<td>2.19492</td>
</tr>
<tr>
<td>1</td>
<td>PostScore</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Summary of Results**

There was a significant relationship between participant’s perception of caring and the years of experience of the registered nurse preceptor with which the student was paired. Examining descriptive statistics showed that students that perceived their nurse preceptors as a facilitator scored higher on the CDI-25, while the other teaching style categories were lower in scores. When investigating clinical units’ role in the perception of baccalaureate nursing students, those students in a neonatal intensive care unit scored lower on the CDI-25, while those in the emergency department scored highest on the CDI-25. There was not a significant difference in caring perceptions of senior-level baccalaureate nursing students after the 225-hour preceptorship experience.

Overall, there was no significance between the time spent in the preceptorship experience and nursing students’ perception of care. However, there was significance in years of experience of the R.N. preceptors on the perception of care of the nursing students. There is also information that can be gained from the descriptive statistics on the primary teaching styles of the nurse preceptors and the type of clinical units the participants were placed on during the preceptorship. Chapter V will discuss the analysis and the research that supports the findings of this study.
CHAPTER V:
DISCUSSION

This chapter presents a summary of the study findings and conclusions drawn from the data presented in Chapter IV. The purpose of this study was fourfold: 1) to determine if there was a relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience; 2) to determine how senior-level baccalaureate nursing students’ perception of caring compared among the primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience; 3) to determine how senior-level baccalaureate nursing students’ perception of caring compared among varying clinical units after a 225-hour preceptorship experience; and 4) to determine if there was a difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience. Rather than broadly looking at how caring attributes change during an undergraduate nursing program, research was conducted to examine how interactions within a specific clinical experience changed nursing students’ perception of care. Chapter V will discuss the study findings and conclusions of the research questions, along with limitations to the study and implications for future research and nursing education.

Findings and Implications to Research Questions

The demographic data and the research questions that directed the study will aid in the discussion and future recommendations for caring ethics education within the nursing
The demographic findings were homogenous in age, gender, and grade point average (G.P.A.). The recruited sample size was 85 participants, however only 31 completed the entire survey and met the inclusion criteria. The age of participants ranged from 20 to 50 years. Twenty-eight participants were in the 22-24 age group (90.3%). There were 26 females (83.9%) and 5 males (16.1%). The approximate grade point average (G.P.A.) was broken down into categories, with the majority of participants (61.3%) having a G.P.A. of 3.5-3.7. The sample was primarily made up of females in their early 20s, with an average G.P.A of 3.6. For this reason, the results of the study cannot be generalized to the population of nursing students as a whole.

The participants were asked if they had prior or current work experience in a health-related field. A total of 22 participants (71%) had prior, current, or both work experience in healthcare related fields. Any type of work in the healthcare industry could affect the way in which the participants perceive caring. It is difficult to determine if the preceptorship hours or the work experience, or even a combination of both, are what causes the change (or no change) in the nursing students’ perception of care.

**Research Question 1**

What is the relationship between the years of experience of registered nurse preceptors and senior-level baccalaureate nursing students’ perceptions of caring after a 225-hour preceptorship experience? This question used the situational narrative lens of S.I. to explore the relationship between the years of experience of registered nurse preceptors and how the students perceived the caring dimensions after the preceptorship experience. Through data analysis with Spearman’s correlation coefficient, it was determined that there is a moderate strength of inverse correlation between the years of experience of the nurse preceptors and the students’ perception of caring. The higher the score on the CDI indicates the participants’ belief that professional and
technical aspects of nursing are perceived as more caring, while lower scores indicate psychosocial aspects are perceived as more caring.

The correlation in this study showed an inverse relationship between years of experience of the preceptor and the nursing students’ perception of care. As the years of experience of the R.N. preceptor increased (more experience), the students scored lower on the CDI-25. This suggested that as the years of experience of the preceptor increases, the nursing students perceived the affective domain as more caring. In contrast, students with preceptors that had less experience perceived caring as a more professional and technical component.

Although there were no cited references in the literature regarding how the years of experience of a nurse changes how nursing students perceive caring, there is literature that can be strengthened by this research. Referring back to the literature, the professionalism shift in nursing had led some theorists to question if traditional caring qualities are being exchanged for scientific and technological caring. Many patients may perceive this type of professional caring as just ‘doing the tasks’ and describe it as ‘noncaring’ (Hawke-Eder, 2017). Other theorists have noted the importance of establishing professional and meaningful relationships with patients (Austgard, 2008; Duffy, 2003; Noddings, 2003; Martinsen, 2000; Sokola, 2013). Specialized knowledge and human interaction is a key component of nursing that sets the profession apart from other health related fields.

Austgard (2008) suggested the meaning and definition of care must come from a superordinate level that can incorporate all aspects of care and discern care from non-care. In nursing, listening to and valuing the beliefs of the patient is the core concept behind the ethics of caring. However, patients still need the specialized skills and knowledge that only nurses can provide. This demonstrates the need for not only compassionate care, but also for knowledgeable
and technical care. Rego et al. (2010) cited caring dimensions as a way to increase professional caring attributes. The explicit need of patients to be cared for, not just satisfied, demonstrates the need for a professional nurse that displays both instrumental and expressive care. Nurses with more experience appear to have a stronger affective domain of caring and those with less experience tend to believe technical skills demonstrate more caring.

Patricia Benner believed clinical judgment comes from practice and expertise in nursing. Benner believed nurses with more experience are more likely to exhibit understanding of the whole person and therefore are able to better care for the individual. She believed that an ethic of care must be learned through practical experiences because they are dependent on ethic conduct in explicit situations (Austgård, 2008). The results of this research question do not confirm that the certain nursing students with preceptors with more experience are able to better care for individuals; instead, it demonstrates how caring can be perceived differently by these individuals.

In addition, over 32% of the participants reported his or her preceptor only had two to three years of experience as a registered nurse. Only one student (3.2%) reported that his or her nurse had more than 40 years of experience. Almost 75% of participants reported that the R.N. preceptor that they were working with had eight or less years of experience.

Within the literature review, Duteau (2012) and Udlis (2006) noted that due to constraints within the hospital, such as increased workload, time constraints and the high turnover rates of nursing staff, preceptors do not always have the experience desired by nurse educators. Oftentimes, preceptors are selected based on availability and willingness to serve (Altmann, 2006). Although this study has a relatively small sample size, it demonstrates the validity in the
literature, with approximately 75% of the R.N. preceptor workforce with eight or less years of experience.

**Research Question 2**

How do senior-level baccalaureate nursing students’ perception of caring compare among primary teaching styles of registered nurse preceptors after a 225-hour preceptorship experience? This question also used the situational narrative lens of S.I. to explore the relationship between the primary teaching style (as perceived by the student) of registered nurse preceptors on baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience. The students were asked to choose which style primarily described his or her preceptors’ primary teaching style. Students were given Figure 1, derived from Grasha (1994) with descriptions of each teaching style. Using descriptive statistics, the data analysis showed the CDI-25 mean scores of the nursing students that identified his or her nursing preceptors’ teaching style as an expert, formal authority, delegator, or personal mode were very close to each other, ranging from 103.25 to 104.33. However, the participants that identified his or her nursing preceptor as a facilitator scored much higher on the CDI-25, with a mean score of 112. Grasha (1993) defined the facilitator as one who “Emphasizes the personal nature of teacher-student interactions; guides students by asking questions, exploring options, suggesting alternatives, and encouraging informed decisions; develop student capacity for independent responsibility; works as consultant on student projects and provides support and encouragement.” The data analysis demonstrates that the nursing students working with facilitators perceived technical skills as more caring, while those identifying preceptors as any of the other four modes perceive caring as more psychosocial in nature. The data infers that interactions with certain types of teacher personalities can change the ways in which a learner creates meaning.
In the literature, Sweet and Broadbent (2017) noted the importance placed on the relational aspect between the facilitator, or preceptor, the student and the organization in which the preceptorship is taking place is on enhancing student learning. Although participants were not asked if the preceptor was effective at clinical instruction, this research can strengthen the literature by demonstrating that different teaching styles of the nurse preceptors can increase or decrease the students’ caring perception scores.

Principle two of S.I.’s core principles states that humans create meaning through social interactions. Exploring RQ1 and RQ2 through the lens of symbolic interactionism validates that some qualities of the nurse preceptor can change the ways in which nursing students perceive care. Smit and Fritz (2012) proposed that identity is developed through the use of the situational, social and personal narratives. The situational narrative emerges from a collective behavior and meaning that is derived during face-to-face interactions and communication with people. For the present study, the situational narrative can be explored by examining how the qualities of the nurse preceptor change nursing students’ perception of care. For RQ1, the students interacting with preceptors with more experience tended to score lower on the CDI-25, which means those students’ perceived caring to be more psychosocial in nature. Inversely, the students with preceptors that had less experience, scored higher overall on the CDI-25, demonstrating the perception of technical skills as more caring in nature. In RQ2, the data suggests that interactions with certain types of teacher personalities can change the ways in which a learner creates meaning. Through interactions and communications with nursing preceptors, students were able to create different meanings of caring. These questions demonstrate that the situational narrative can be a powerful tool in changing the perceptions of nursing students.
Research Question 3

How do senior-level baccalaureate nursing students’ perception of caring compare among varying clinical units after a 225-hour preceptorship experience? This research question examined how nursing students’ caring perceptions compared to the type of clinical unit in which they were placed. The question also sought to explore the situational component of symbolic interactionism within the nursing preceptorship experience.

For this question, the units were broken into multiple categories. Participants were asked to choose the location of his or her preceptorship from the list of the following units: adult medical-surgical, adult intensive care unit, operating room, emergency department, labor and delivery, post-partum women’s unit, neonatal intensive care unit, pediatric intensive care unit, pediatric medical-surgical units, adult psychiatric unit, pediatric psychiatric unit, or other.

Descriptive statistics were examined and analyzed. The neonatal intensive care unit (NICU) had a total mean score of 102.80, while the emergency department (ED) had a mean score of 110.80. Besides the adult medical-surgical unit and “other” that one participant chose each, these are the highest and lowest means of the clinical units. Using the CDI-25 scoring system, students in the NICU preceptorship unit perceive caring as a more psychosocial aspect, while those precepting in the ED perceive caring as a more professional and technical aspect.

The descriptive statistics for this research question paint a picture of varying perceptions of caring within different environments. The students caring for infants in the NICU scored much lower on the CDI-25, demonstrating the affective domain was perceived as more caring, while the students working in the area of the adult emergency department scored higher on the CDI-25, demonstrating the technical domain was perceived as more caring. The findings suggest that certain clinical environments may change the ways in which a nursing student perceives
caring. The NICU is a low-stimulant environment, where nurses’ primary role is to care for the physical and psychosocial needs of infants. The ED is known for being a fast-paced environment, where nurses must be proficient at focused assessments and skill attainment on adults. While both units focus is on caring for ill patients, there are differences in the ways in which the nurses care for the individuals.

Natale and Klevay’s (2013) believed that it is essential for educators to create environments that allow students to learn from others and to be present in the care. It is essential for educators to find creative ways in which to teach students not only technical skills, but also strengthen the affective domains. Meaningful experiences created in purposeful environments are key to developing relationships and connecting with others in nursing. Looking through the lens of symbolic interactionism, the social identity can be derived from the social narrative, that is, how the qualities of the precepting environment can change the ways in which a nursing student views caring. When students are placed in certain environments, the meaning of caring they hold may be altered. The results of this question demonstrates that the clinical environment may change how the nursing student perceives care. With the understanding that certain environments can strengthen the affective or technical domain of caring, nursing education can use this information to inform decisions on clinical placements throughout the curriculum.

**Research Question 4**

What is the difference in senior-level baccalaureate nursing students’ perception of caring prior to a 225-hour preceptorship experience compared to senior-level baccalaureate nursing students’ perception of caring after a 225-hour preceptorship experience? This question was used to determine the difference, if any, between the amount of hours of preceptorship and senior-level baccalaureate nursing students’ perception of care after a 225-hour preceptorship.
experience. The data analysis showed that there was not a significant difference in scores of the caring dimensions inventory from prior to the preceptorship experience and post preceptorship experience.

Much of the research conducted on caring attributes and behaviors on nursing students suggested that caring abilities decreased during nursing school (Ma et al., 2013; Murphy et al., 2009). It is difficult to relate caring behaviors and abilities to the dimensions of care; however, it is interesting to compare and contrast the results with the studies in the literature. Using the CBA, Omari et al. (2013) demonstrated that perceived cognitive aspects of care, particularly teaching behaviors, were the most important while caring for individuals. The nurses also believed the psychological aspect of caring to be very important, such as listening to the needs of the patients and treating patients with respect. In addition, Watson, Deary, and Lea (1999b) found a decrease in caring scores after studying caring dimensions of nursing students after one year in a nursing program.

There were studies in literature demonstrating an increase in caring scores. Khademian and Vizeshfar’s (2007) study demonstrated nursing students perceived practical behaviors as demonstrating more caring on the part of the nurse than emotional behaviors. In addition, Simmons and Cavanaugh (2000) found that caring abilities actually increased post-graduation and entry into nursing practice. Even though the students were still enrolled in the nursing program, the preceptorship experience in the present study closely mimics the work of nurses in practice.

RQ4 addressed how the personal identity can be created through personal narratives. Personal identity is developed through individual narratives. Persons may choose to select or remove information that builds his or her identity depending on the audience. For the present
study, personal narrative was identified as the individual students’ perceptions of care. The question answered how time spent with the preceptorship program shaped how students perceived care. Even though students were exposed to all types of preceptorship experiences, each individual had to determine how it would shape their personal identity. Although, there was not a significant change in how students perceived caring after time spent in the preceptorship experience, it is difficult to say with certainty that personal identities did not change. Figure 6 shows the results of the study within the modified version of Smit and Fritz’s (2008) model.

![Figure 6](image)

*Figure 6. Use of Smit and Fritz’s (2008) model following data analysis to explore changes in caring dimensions as perceived by nursing students after a preceptorship experience*
From the lens of symbolic interactionism, there needs to be further explanation of what is happening within the interactions. Though the research question ultimately showed no significant change in the caring perceptions of students after time spent in the preceptorship, the interactions happening within the preceptorship could possibly cancel out each other. Each individual experienced a variety of different interactions during their experience that ultimately shaped their personal identity and how they perceived care within the setting, with the particular patient population.

**Limitations**

The study had limitations surrounding both the data collection and the sample population and size. During data collection, participants were asked to choose a range of years for multiple categories. This made it difficult to analyze the data in the way the researcher intended it to be analyzed. For example, when asked for years of experience of the RN preceptor, a single number would have lent itself to richer description than a broad category of multiple years.

In addition, when participants were asked to choose a unit description of where the preceptorship experience was completed, the unit descriptions did not catch all responses as one participant chose ‘other’ as his or her unit description. The units could have also been grouped together to gain a better picture of the types of units and how the students on those units perceived care. Units with similar characteristics, such as a high acuity, which would typically focus on performing skills could have been grouped together. For example, intensive care units and the emergency department could have been grouped together, while all women’s and children’s services could have been grouped. This may have allowed the researcher to run additional statistical analysis to determine the relationship of the unit groupings on the students’ perception of care.
The researcher also did not collect characteristic information from the preceptors. It would have been helpful to know what general characteristics the preceptors had, such as age and gender. It would have also been helpful to have the preceptor chose his or her primary teaching style and compare those responses to the nursing students’ responses. There was a lot more to learn from the preceptor side in this study.

In addition, the researcher did not obtain identifiers during the mid-point of the preceptorship to gain an understanding of how the time difference changed the students’ perception of care. Data were collected during the mid-point of the preceptorship program; however, it was discarded since there were no identifiers to link the mid-point data back to the original data. Another limitation was the sample selection was one of convenience. The sample was homogeneous in both age, gender and grade point average, which made the results less generalizable.

A major limitation was the number of students that agreed to participate in the study. Due to time constraints, the researcher presented the study prior to a high-stakes nursing exam. The timing made it difficult to recruit participants. The time it took to complete the stages of the data collection was also a limitation. Originally, 35 students completed the first round of data collection; however, only 32 participants complete both the first and final round of data collection. One of those participants missed one question on the CDI-25 survey tool, so the results from his or her survey was thrown out, since the total of the CDI-25 could not be calculated for that participant. The limitations in the population size ultimately affected the ways in which the researcher could analyze the data. It was the intent to perform regression analysis for some of the data, but there was not enough in the sample size to do so in a valid manner.
Recommendations for Future Research

Further research is needed in the area of preceptorships’ use in nursing education, with an emphasis on the length of time for preceptorships, and what other factors, both environmental and socially, can influence the ways in which students learn behaviors. Additional research on caring ethics within nursing education is needed to develop new and innovative strategies that will continue to address the caring crisis that is evolving in the nursing profession. Another recommendation would be to replicate this study in a larger and more diverse population, utilizing shorter and longer time frames for preceptorship experiences. In addition, a longitudinal study across the entire nursing program and into practice would lend itself to rich data that could be used to inform clinical education in the future. Another suggestion is to further investigate how nurse preceptors identified as facilitators by participants caused such an increase in the technical scores of the student preceptors.

This study could also be expanded upon by using a qualitative research design. The theoretical framework of symbolic interactionism could be used as a lens to view the experiences of the nursing students’ perception of care as it related to the preceptorship program. Such qualitative data could lend to rich descriptions of how the students perceive his or her caring attributes, while also learning more about which factors create the greatest difference in caring.

This study was intended to lay the foundational groundwork in studying what interactions within the nursing clinical curriculum can change the ways in which students perceive care. This study examined interactions on a macro dynamic level. The study demonstrated that practical experience can change how someone perceives care. This study should be expanded upon to gain an understanding of how these interactions are changing the students’ perception of care on a more micro dynamic level.
Recommendations for Nursing Education

The findings of this study demonstrate the importance of clinical education, particularly preceptorship experiences, on caring ethics education in nursing. Nursing education can utilize preceptorships for increasing the skills set of nurses and changing the ways in which students perceive care. Further evaluation of the relationship between preceptorships and the characteristics that influence students the most during preceptorship experience will continue to improve upon the overall clinical experiences of nursing students. Exploring characteristics of nurse preceptors will lend itself to ensuring the best learning environments for students.

In addition, Moyano (2015) suggested professional caring requires both the technical and human dimensions. He suggested caring for someone is impossible utilizing a single dimension, therefore, making it impractical to measure care in a strict way. He also suggests nursing educators should teach technical aspects of the profession, while also providing students with tools to deal with the ethical dilemmas that must be dealt with daily. Many of the studies in the literature suggest caring abilities decrease while in nursing school, but without an understanding of multiple caring dimensions, it is difficult to state that someone is more or less caring. Instead, nurse faculty should educate students on how care can be delivered from varying perspectives. The caring crisis in nursing comes from a disconnection between how nurses and patients actually perceive care, as Kerfoot (1996) suggested when he found that patients received excellent technical care, but were unsatisfied with their overall care if their emotional needs had not been met appropriately. Professional caring must encompass both technical and emotional behaviors.

Nursing education can move forward in correcting this imbalance of understanding by preparing students in both the affective and technical domains of caring and how to holistically
care for individuals. With the understanding that certain environments and characteristics of instructors can strengthen the affective or technical domain of caring, nursing education can use this information to inform decisions on clinical placements throughout the curriculum. This study also demonstrates the importance of utilizing one-on-one precepting environments to aid in caring ethics education. Further evaluation into clinical education’s role in caring ethics training is needed to determine which factors help to create the best learning outcomes.

Conclusion

As the profession of nursing continues to evolve, it is imperative for nurse educators to continually assess how students are being taught to deliver competent and compassionate care to patients. Moyano (2015) suggested professional caring requires both the technical and human dimensions. He suggests caring for someone is impossible utilizing a single dimension, therefore, making it impractical to measure care in a strict way. Unfortunately, patients do not always perceive care in the same manner as those caring for them, but by expanding caring ethics education, the gap in care may be decreased.

Preceptorships have been proven to be a valuable addition to the clinical education in nursing programs (Sandvik et al., 2014; Duteau, 2012; Happell, 2009). The present study also demonstrates that preceptorships can be used to add value to the caring ethics education a student receives while in nursing school. The present research discovered a significant relationship between the years of experience of a nurse and the caring perceptions of baccalaureate nursing students. The research also concluded that nursing students demonstrated an increase in the technical domain of caring after working in certain clinical units and with nursing preceptors who were classified as facilitators.
Although there was not a significant difference in the pre- and post-scores of the CDI-25, the study found that nursing students did value technical aspects of caring more than psychosocial aspects after the preceptorship experience. The research found valuable data suggesting characteristics of nurse preceptors and units did cause differing values on the CDI-25. This data demonstrates that certain variables creates a change with student perceptions of care. This study opens the doors for more research to ensure that nursing education is preparing graduates who can competently and compassionately care for individuals.
REFERENCES


Saunders J. (1997) Walking a mile in their shoes...symbolic interaction for families living with severe mental illness. *Journal of Psychosocial Nursing & Mental Health Services, 35*(6), 8-13, 45-46.


APPENDIX A:

DEMOGRAPHIC INFORMATION FORM

Age:
19-21
22-24
25-30
31-40
41-50
51-60
61 and over

Gender:
Male
Female
Choose not to answer

Approximate overall GPA:
4.0-3.8
3.7-3.5
3.4-3.1
3.0-2.8
2.7-2.5
2.4-2.1
2.0 and below

Upper Division Nursing GPA:
4.0-3.8
3.7-3.5
3.4-3.1
3.0-2.8
2.7-2.5
2.4-2.1
2.0 and below

Prior or current job in healthcare setting?
Yes
No
APPENDIX B:

PRECEPTORSHIP EXPERIENCE QUESTIONNAIRE

Preceptorship location:

Type of unit or floor:

- Adult Medical-Surgical
- Adult Intensive Care Unit
- Surgical services
- Emergency Room
- Labor and Delivery
- Post-partum floor
- Neonatal Intensive Care Unit
- Pediatric medical-surgical
- Pediatric Intensive Care Unit
- Other:

Preceptor characteristics:

Educational background:
- ADN
- BSN
- MSN
- Doctorate in Nursing
- Other

Number of years practicing as an RN:
- 0-1
- 2-3
- 4-5
- 6-8
- 9-12
- 13-16
- 17-21
- 22-29
- 30-39
- 40-49
50 and up

Number of years practicing on the assigned unit:
0-1
2-3
4-5
6-8
9-12
13-16
17-21
22-29
30-39
40-49
50 and up

Please choose which style best describes your preceptor’s teaching style:

<table>
<thead>
<tr>
<th>Five Teaching Styles</th>
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<tbody>
<tr>
<td>Expert</td>
<td>Possesses knowledge and expertise that students need. Strives to maintain status as an expert by displaying detailed knowledge and challenging students to enhance their competence. Concerned with transmitting information and ensuring that students are well prepared.</td>
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<td>Formal Authority</td>
<td>Possesses status among student because of knowledge and role as a nurse. Concerned with providing positive/negative feedback, establishing learning goals, expectations, and rules of conduct. Concerned with “correct, acceptable, and standard ways to do things.”</td>
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<td>Personal Mode</td>
<td>Believes in “teaching by example,” establishes a prototype for how to think and behave. Oversees and directs by showing how to do things and encouraging students to observe and then emulate the instructor’s approach</td>
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<td>Facilitator</td>
<td>Emphasizes the personal nature of teacher-student interactions. Guides students by asking questions, exploring options, suggesting alternatives, and encouraging informed decisions. Develop student capacity for independent responsibility. Works as consultant on student projects and provides support and encouragement.</td>
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<tr>
<td>Delegator</td>
<td>Concerned with developing students’ capacity to function autonomously. Students work independently on projects or as part of autonomous teams. The teacher is available at the request of students as a resource.</td>
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(Grasha, 1994)

TRUE/FALSE- I have completed all 225-hours of preceptorship
APPENDIX C:

25-ITEM CARING DIMENSIONS INVENTORY (CDI-25)

Stem question: Do you consider the following aspects of your nursing practice to be caring? (Watson & Lea, 1997)

Respond on a five-point Likert Scale: 1 (strongly disagree) to 5 (strongly agree)

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<tr>
<th></th>
<th>1- strongly disagree</th>
<th>2- disagree</th>
<th>3-Neither agree nor disagree</th>
<th>4- agree</th>
<th>5- strongly agree</th>
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<tbody>
<tr>
<td>1.</td>
<td>Assisting a patient with an activity of daily living (washing, dressing, etc.)</td>
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<td>2.</td>
<td>Making a nursing record about a patient (charting on the patient)</td>
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<td>3.</td>
<td>Feeling sorry for a patient</td>
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<td>4.</td>
<td>Getting to know the patient as a person</td>
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<td>5.</td>
<td>Explaining a clinical procedure to a patient</td>
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<td>6.</td>
<td>Being neatly dressed when working with a patient</td>
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<td>Sitting with a patient</td>
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<td>8.</td>
<td>Exploring a patient’s lifestyle</td>
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<td>Reporting a patient’s condition to a senior nurse</td>
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<td>10.</td>
<td>Being with a patient during a clinical procedure</td>
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<td>11.</td>
<td>Being honest with a patient</td>
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<td>12.</td>
<td>Organizing the work of others for a patient</td>
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<td>13.</td>
<td>Listening to a patient</td>
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<td>14. Consulting with the doctor about a patient</td>
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<td>15. Instructing a patient about a aspect of self-care (washing, dressing, etc.)</td>
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<td>16. Sharing your personal problems with a patient</td>
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<td>17. Keeping relatives informed about a patient</td>
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<td>18. Measuring vital signs of the patient (e.g. pulse and blood pressure)</td>
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<td>19. Putting the needs of a patient before your own</td>
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<td>20. Being technically competent with a clinical procedure</td>
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<td>21. Involving a patient with his or her care</td>
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<td>22. Giving reassurance about a clinical procedure</td>
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<td>23. Providing privacy for a patient</td>
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<td>24. Being cheerful with a patient</td>
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<td>25. Observing the effects of the medication on a patient</td>
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Dear Dr. Watson,

My name is Amanda Barron and I am a doctoral student at the University of Alabama in the United States. I am currently working on my dissertation for the partial fulfillment of my EdD and I would appreciate your help in my study. I am hoping to research the effects of senior practicums on Baccalaureate nursing students’ ability to care and their perceptions of caring dimensions. I am hoping to examine changes in their perceptions of caring dimensions through the use of the Caring Dimensions Inventory. I would like to utilize the 35 item version of the CDI as I believe it will give me the most useful data for my study. I am writing to ask for permission to use the CDI. If you do grant me permission, I would also like to ask if there are others that I need to write for permission as well. I could only find your correspondence. I can assure you that you will receive full credit for the instrument and any other acknowledgement that you request. I will also ensure that you receive a full copy of the manuscript once it is completed. If you have any questions, please feel free to contact me.

I appreciate your time and help,

Amanda Barron
alramsey@crimson.ua.edu
256-393-7788

Roger Watson <R.Watson@hull.ac.uk> 7/6/15

Dear Amanda

There is no copyright on the CDI so no permission needed.

Thanks

Roger

Roger Watson PhD FRN FRCN FRCP Edin FAAN
Editor-in-Chief, Journal of Advanced Nursing
Editor, Nursing Open
Professor of Nursing, University of Hull, UK
Follow me on Twitter @rwatson1955
http://twtbizzcard.com/rwatson1955
Mobile +447808480547
Skype roger.watson3
“The plural of anecdote is not data”
Sent from my iPad
Dear Dr. Watson,

I reached out to you two years ago regarding a dissertation study I was working to complete. I am still in the process of completing the dissertation and wanted to reach out to you again. I have decided to use the CDI-25 instead of the CDI-35. I wanted to verify that there is no copyright on the CDI-25.

Thank you so much for your time.
Amanda Barron

---

Roger Watson

to me

Dear Amanda

Correct - feel free to use

Roger
APPENDIX E:

LETTER OF INVITATION

Invitation to participate in the research project titled: “The Impact of Preceptorships on Baccalaureate Nursing Students”

Dear Capstone College of Nursing senior student,

I am conducting a series of surveys as part of a research project to increase the understanding of how preceptorship experiences can change nursing students’ perception of care. As a senior level nursing student preparing to enter into the preceptorship program at The University of Alabama, you are in an ideal position to provide valuable information from your perspective. The study will include a series of three surveys. A survey link will be sent to you via email. The first survey and demographic information sheet will take approximately 15 minutes of your time. I will send you another invitation email with the Qualtrics link in approximately 3-4 weeks. This will take approximately 10 minutes. The third survey will be sent to you after you have finished all 225 hours of preceptorship and will again take around 15 minutes to complete. Your responses to the questions will be kept confidential, as the researcher will have no link to your user name, password or IP address. There is no direct compensation for participation in this survey; however, if you choose to participate, you can choose to be placed in a drawing for (3) $50 gift cards to be given out at the completion of the study. Your participation is completely voluntary and you will not be penalized for not participating. However, your participation will add significant value to the overall understanding of how the qualities of preceptorship can affect nursing students’ perception of care. If you have any questions, please do not hesitate to ask.

Thank you for your time and consideration,

Amanda L. Barron
EdD Candidate

Please click on the link below to begin this study.
APPENDIX F:
INFORMED CONSENT

UNIVERSITY OF ALABAMA
HUMAN RESEARCH PROTECTION PROGRAM

Informed Consent for a Non-Medical Study

**Study title:** The Impact of Preceptorships on Baccalaureate Nursing Students’ Perceptions of Care  
**Amanda Barron, EdD student at the University of Alabama**

You are being asked to take part in a research study. This study is called The Impact of Preceptorships on Baccalaureate Nursing Students’ Perceptions of Care. The study is being done by Amanda Barron, who is a graduate student at the University of Alabama. Ms. Barron is being supervised by Vivian Wright who is a professor of Education at the University of Alabama.

**Is the researcher being paid for this study?** No, the research is not being funded by any outside source.

**Is this research developing a product that will be sold, and if so, will the investigator profit from it?** No. There will be no product development from this research study.

**Does the investigator have any conflict of interest in this study?** No.

**What is this study about? What is the investigator trying to learn?**
This study is being done to examine the relationship between the amount of hours, locations and expertise level of the registered nurse preceptor during a baccalaureate nursing program’s preceptorship experience on the senior-level nursing students’ perceptions of care. The investigator is trying to learn what types of characteristics of the preceptorship experience can aid in the development of varying caring characteristics.

**Why is this study important or useful?**
This knowledge is useful because it will demonstrate the importance of hands-on clinical education in strengthening professional caring behaviors of nursing students. In addition, this study will inform the most appropriate amount of hours for a preceptorship experience in relation to teaching caring ethics to nursing students. The study will also aid in providing recommendations for specific units and qualities of registered nurse
preceptors to help design quality preceptorship experiences that also build caring attributes of nursing students.

**Why have I been asked to be in this study?**
You have been asked to be in this study because you are a currently enrolled senior level baccalaureate nursing student participating in a 225-hour preceptorship this semester.

**What will I be asked to do in this study?**
If you agree to participate in this study, you will be asked to do these things:
- Complete all 225-hours of preceptorship prior to December 8, 2017
- Complete a demographic information form
- Complete a 25-item Caring Dimensions Inventory (CDI-25) on three separate occasions: one prior to the preceptorship experience, one approximately half-way through the preceptorship experience and one at the completion all 225-hours of preceptorship
- Complete a preceptorship experience questionnaire following the 225-hour preceptorship experience

**How much time will I spend being this study?**
A total of 40 minutes is estimated as the time it will take to complete all portions of this study. Approximately 15 minutes will be required to finish the demographic sheet and CDI-25 prior to the preceptorship experience, approximately 10 minutes will be required to complete the CDI-25 during the half-way point of the preceptorship experience, and approximately 15 minutes will be required to complete the final CDI-25 and the preceptorship experience questionnaire.

**Will being in this study cost me anything?**
The study will not cost you any monetary items.

**Will I be compensated for being in this study?**
In appreciation of your time, you can choose to be placed in a drawing for one of (3) $50 gift card.

**Can the investigator take me out of this study?**
The investigator may take you out of the study if she feels that something happens that means you no longer meet the study requirements.

**What are the risks (dangers or harms) to me if I am in this study?**
There are no foreseen risks involved in participation in this study.

**What are the benefits (good things) that may happen if I am in this study?**
Although you will not benefit personally from being in the study, you may feel good knowing that you have helped to improve upon the preceptorship program for future nursing students.
What are the benefits to science or society?
This study has far-reaching implications for nursing education as it could demonstrate the importance of hands-on clinical education in strengthening professional caring behaviors of nursing students. In addition, this study will inform the most appropriate amount of hours for a preceptorship experience in relation to teaching caring ethics to nursing students. The study will also aid in providing recommendations for specific units and qualities of registered nurse preceptors to help design quality preceptorship experiences that also build caring attributes of nursing students.

How will my privacy be protected?
Privacy refers to people and other people’s access to them.
Your privacy will be protected by allowing you to complete the CDI-25, demographic forms, and preceptorship experience forms using the Qualtrics online system. The Qualtrics online system maintains privacy by not allowing the researcher access to the participants IP address.

How will my confidentiality be protected?
Confidentiality refers to data and how it will be safeguarded.
Qualtrics will identify participants without the use of names; however, you will be asked to give the last four digits of your student identification number to maintain consistency in the data collection. Any printed copies of the data will be stored in locked boxes, restricting the number of people that can access data, and destroying all raw data and any identifiers after data has analyzed.

What are the alternatives to being in this study? Do I have other choices?
The alternative to being in this study is not to participate.

What are my rights as a participant in this study?
Taking part in this study is voluntary. It is your free choice. You can refuse to be in it at all. If you start the study, you can stop at any time. There will be no effect on your relations with the University of Alabama, nor will this impact your success in the preceptorship course.

The University of Alabama Institutional Review Board ("the IRB") is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?
If you have questions, concerns regarding this study, please contact the investigator Amanda Barron at alramsey@crimson.ua.edu or the dissertation committee chair, Dr. Vivian Wright at vwright@ua.edu
If you have questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the University Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

I have read this consent form. I have had a chance to ask questions. I agree to take part in it. Please click one of the following: AGREE/DISAGREE
APPENDIX G:

IRB APPROVAL

THE UNIVERSITY OF ALABAMA
Office of the Vice President for Research & Economic Development
Office for Research Compliance

October 11, 2017

Amanda Barron
College of Education
Box 870302

Re: IRB #: 17-OR-315 “The Impact of Preceptorships on Baccalaureate Nursing Students’ Perception of Care”

Dear Ms. Barron:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. You have also been granted the requested waiver of written documentation of informed consent. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

Your application will expire on October 9, 2018. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Request for Study Closure Form.

Please use reproductions of the IRB approved stamped consent form to provide to your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

[Signature]
Director & Research Compliance Officer

358 Rose Administration Building | Box 870127 | Tuscaloosa, AL 35487-0127
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-820-3066