ORIGINAL RESEARCH

Development of a CPD program on caring nursing practice for hospital nurses: A mixed-methods study

Tonia Naylor*

The University of Notre Dame Australia, Australia

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ABSTRACT

Continuing Professional Development (CPD) is able to enhance and support caring nursing practice; however, the relationship has never been reported in Western Australia (WA). The aim of this study was to develop a CPD program on caring nursing practice for hospital nurses. A descriptive and exploratory mixed methods approach was used for the research. The research is reported using a three step curriculum development model: (1) development, (2) implementation, and, (3) evaluation - discussion. Findings confirmed that CPD is able to enhance and support caring nursing practice in WA hospitals. The extent to which it is able to do this is limited by cultural, organisational, interprofessional, nursing and personal factors beyond the reach of the CPD program.

Key Words: Caring, Professional-development, Health paradigm, Curriculum development, Interprofessional education, Nurse, Education

1. INTRODUCTION

This research emerged from the shock of numerous damning reports about a lack of caring in nursing in Australia[1,2] and internationally.[3,4] The reports exposed an horrific lack of caring, leading in extreme cases to criminal prosecution of health care workers and health care providers. There have been an increasing number of appeals to return to caring in nursing,[5,6] indicating there is a popular conception that caring is central to nursing. The overarching conclusion of multiple reports however, indicated lack of caring resulted from a systemic lack of caring in the health sector involving many inter-related factors rather than one factor.[1,3]

Three recurring themes about the context of caring and nursing emerged from the literature and popular culture: first, there is a complex interplay of competing factors which affect nursing and health care outcomes; second, caring is said to be the central activity of nursing; third, caring is said to be an innate quality of nurses. Literature was analysed for recurring themes using standard thematic analysis. Each is dealt with separately below.

The first recurring theme: the complex interplay of competing factors which affect nursing and healthcare outcomes require 'a number of individual, collegial as well as organisational strategies'.[6,7] These factors exist within competing health care paradigms. For example, in Western Australian (WA) the government requires that 'organisations strive to demonstrate the same care and attention to their staff that they expect staff to demonstrate towards patients and families', whilst at the same time acknowledging the inconvenient truth that . . . There needs to be a continuing focus on 'budget controls' and an imperative for health to 'live within its means'. Caring and economic paradigms compete for a balanced approach to health care. Continuing Professional Development (CPD) is one strategy aimed at supporting nursing practice

*Correspondence: Tonia Naylor, PhD, BEd (Hons.), BSc, RN. Email: tonianaylor7@gmail.com; Address: The University of Notre Dame Australia, Australia.

within competing paradigms.[6]

In Australia, CPD for health professionals is regulated by the Australian Health Practitioner Regulation Agency (AHPRA).[7] The minimum amount of CPD time for the purpose of annual reregistration is different, for each profession. Australia nurses are required to demonstrate 20 hours of CPD per year. The amount of paid time employers are prepared to contribute towards CPD varies across employers and industrial awards. In addition employers are able to direct CPD budgets in a ways which are congruent with the organisations values, goals and outcome measures. Organisations therefore control what and how much paid CPD is available to nurses in their organisation. For example, if nurses want to attend CPD which is not supported by their employer they either don't attend or, pay for it themselves. Through these approval processes organisations reflect their approach to managing the competing paradigms of economics and care.

The second recurring theme: caring is a central activity of nursing and its absence affects patients, staff, and organisations. Research shows caring has a direct impact on patient outcomes;[8] its absence negatively affects patient outcomes;[9–11] caring is seen to bring meaning and dignity to nursing;[12] and its absence negatively affects retention of nursing staff,[11,13] and workplace environment.[14] An inability to care is reported to be one of the major reasons for nursing staff attrition.[15]

The third theme: a good nurse is a caring nurse.[9,13] The popular expectation that a 'good nurse' is a 'caring nurse' has substantial support in nursing theory and research. It is recognised, however, that 'goodness', as a concept, may be classified as an ethical, moral matter, or as a personal judgement. Ideas of what constitutes a 'good nurse' are continually changing.[16] Some of the key components of caring found in most contemporary definitions of caring as it relates to nursing are: presencing, sharing, supporting, competence, uplifting effects, being respected, belonging, growth, transformation, learning to care, desire to care.[17] Also included are compassion – which is a 'display of character . . . leading to concern for the good of others, an awareness of the others suffering and a desire to act to relieve that suffering[18]', and empathy.[18] The question of whether this caring quality is innate or learnt and whether it can be taught has emerged as a key theme in nursing theory, research, and practice.[12,19] The question is central to this research.

The purpose of the study was to develop a CPD program which aligned with professional and social expectations of caring within the context of competing health care paradigms; research evidence linking caring and nursing, and expectations that caring is a central activity of nursing.

2. METHODS

The researchers' aim was to develop and evaluate a CPD program for hospital nurses in Western Australia (WA) which supports caring nursing practice. The research took place between 2016-2020 with data collection commencing in 2018.

The purpose of the CPD program was to support nurses, to meet individual, professional, organisational and social expectations of the caring nurse. The research used a descriptive and exploratory[20] mixed methods approach which employed both qualitative and quantitative approaches.[21] The purpose of this paper is to describe the development of the CPD program from an educational viewpoint and present it using a three step curriculum development format: (1) development (2) implementation (3) evaluation - discussion.

2.1 Development

Six development activities are described very briefly. These activities were approached iterative rather than stepwise.

2.1.1 *Identifying need*

In this instance, the need is predetermined. It is based on: reports indicating serious deficits in caring in WA and globally; calls for a return to caring in nursing; and a system level lack of CPD on caring in WA.

2.1.2 *Determining and prioritising content*

To determine and prioritise content, a comprehensive literature review was conducted. It incorporated research and theory from four fields: nursing, education, sociology, and philosophy. A key difficulty for educators is in determining whether caring can be taught to nurses. Researchers and theorists have difficulty in qualifying and quantifying the concept which is at the core of what is to be taught - caring. One article concluded with an observation "I like to think that caring is a teachable phenomenon in nursing. But if I am wrong, I have at least done my best to instil a habit of caring in my students".[22] The distinction between caring and the habit of caring is important. It is at the centre of the ongoing well published debate about 'a caring science' or a 'science of caring'.[21] This philosophical debate goes to the heart of ontology and epistemology of caring and nursing and has a direct impact on content and delivery of a CPD program on caring. On the one hand science may quantify and qualify caring but on the other hand that quantification and qualification is limited to the scientifically observable phenomenon of caring. That is, those nurses demonstrating caring attributes may (1) simply be 'acting' in a way consistent with 'caring' or (2) may be practicing from an internalized caring ethic.

Praxis (not practice) is a union of head and heart in action. So, while science is able to quantify and qualify action it is probably not possible at this point in science to determine

whether the head and heart are in unison with action. For example: when observing a nurse supporting a grieving relative it may be possible to observe outward manifestations of caring – a gentle tone to the voice, allowing the person to explore their feelings, ensuring the deceased relative is presentable for family and so forth. What cannot be seen is whether the person actually cares: whether caring is integrated into the persons sense of being and manifests as caring. Most of us are aware of the 'Would you like chips with that? Have a good day' form of organisationally mandated caring.

While the aim was to provide a CPD program on caring nursing practice for hospital nurses, it was hoped that the CPD program would at least support good habits by providing content knowledge about organisational, professional and cultural expectations with regards to practice. More importantly it was hoped that the CPD program would also provide opportunity for those who wished to move to or deepen caring praxis.

As Jane Sumner observed, real caring may require personal growth.

> I had imprinted onto me as a very young student nurse the duty and obligation of nursing, which I accepted but when I grasped that all humans are vulnerable in need of considerateness I could acknowledge my humanness as a nurse and my own need for considerateness. Thus Habermas's (1995) theory of Communicative Action and Moral Consciousness was the seminal work for me, enabling me to dissect the nurse into professional self and personal self and the patient as illness self and personal self and then what occurs in the interaction. The nurse and the patient as a whole could, at last, be offered, and how emotion and thinking of each could influence what was going on, in the interaction.[23]

Sumner[23] goes further to hypothesis that the capacity to reflect may be linked with moral maturity.

The educational implications for providing a program which met all levels of caring were profound. It meant the difference between 'teaching about caring' versus 'teaching to care'. Praxis may be more difficult to teach than providing theoretical content 'about' caring, however, as Alpers, et.al (2013) imply there is an assumption that content knowledge translates into action. Praxis requires deep learner engagement which may be limited by moral maturity.[24]

2.1.3 *Articulating: Aims, objectives, and assumptions*

The aims, objectives, and assumptions, were formulated from identified needs emerging from practice and a comprehensive literature review:

1) Develop and deliver a CPD program caring nursing practice that aligns with professional and social expectations of caring nursing practice in the context of competing health care paradigms.
2) Evaluate the extent to which the CPD program on caring nursing practice can support caring nursing practice in Western Australian hospitals.
3) Make recommendations on provision of CPD programs supporting caring nursing practice in WA hospitals.

2.1.4 *Selecting teaching/educational strategies*

Teaching methodology aimed to move participants from knowledge acquisition through critical enquiry to praxis. Four theoretical perspectives were considered and applied to the development of the CPD program: Kolb,[25] Bloom,[26] Bolton,[27] and Maslow.[28] The CPD program consisted of two components: a one day Master Class (MC) and optional supplementary reflective practice journaling (RPJ),[29] providing an additional opportunity for participants to engage more deeply with caring and nursing. In essence the CPD program was developed with the intention of moving adult learners[30] from simple to integrated practice (praxis). This required more than meeting cognitive teaching and learning needs. It also required engaging participants in ever deepening and broadening cycles of critical thinking and reflective practice (see Figure 1).

Figure 1, shows the use of the four theorists who informed development of the CPD program. Participants moved from fundamental learning and concrete experiences to higher order thinking which integrates thought and action (praxis), through the use of a critical thinking and reflective practice. Maslow's motivation of human needs theory was fundamental to the CPD program.

2.1.5 *Preparing the teaching content and teaching/learning experiences*

Teaching content and teaching/learning experiences were developed to provide knowledge about practice and experience with critical thinking and reflective practice. The content and teaching/learning experiences of the CPD program is summarised in the CPD outline (see Table 1).

2.1.6 *Development of the evaluation plan*

A traditional pre-post evaluation was used to sequence evaluation. The aim of the evaluation was to determine learning gains across content knowledge and experiences in the CPD program: MC and RPJ. A survey was used to collect qualitative and quantitative data of MC and RPJ participants prior to analysis, discussion, implications and recommendations (see Figure 2).

In addition to standard data collection methods outlined in Figure 2, informal teacher observations were used throughout the MC.[32]

2.1.7 *Data collection tools*

Qualitative and quantitative survey data were compared across three time frames. Survey and RPJ data were compared before comparing findings with the literature.

A survey tool was developed. It consisted of four groupings of data: (1) demographics of participants (2) data to assess emotions and motivations about nursing and caring, (3) data to determine caring efficacy using an established caring efficacy scale[33] tested for reliability and validity of use in Australia[34] and, (4) data to determine content knowledge learning gains. In total there were 80 questions eliciting both quantitative and qualitative responses.

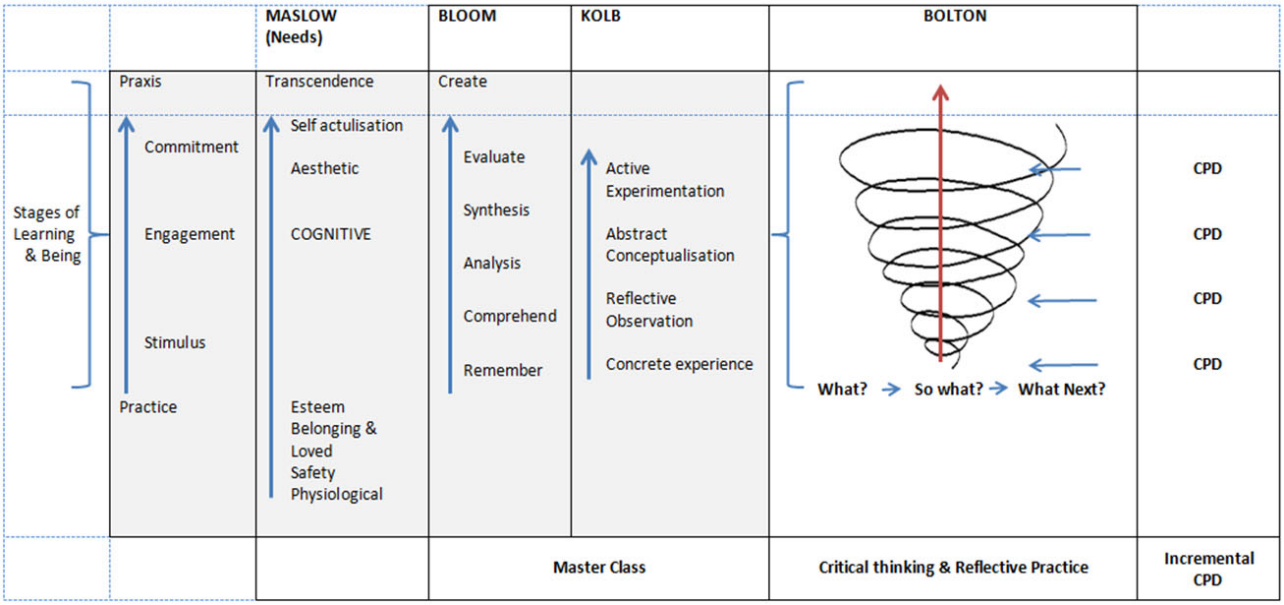

Figure 1. Education for praxis: From knowledge and practice through to praxis

The survey was designed to answer questions about who the participant were (1 & 2), how confident they felt to nurse (3) and the impact of teaching and learning (4).

Reflective practice journaling did not use a predetermined format. Participants were encouraged to use a basic three step critical thinking format for reflective practice: What? So What? What next?[27]

2.1.8 *Trial and modification of the CPD program*

A dialogic expert group (N = 8) consisting of senior nurses from education, research and executive reviewed the program for face validity. Dialogic pedagogy is a term used to describe specific dialogue interactions. It is a two way discourse in which two way learning occurs as a group while critically interrogating a topic. It allows for multiple voices, points of view in a respectful environment.[35] The expert group were provided with copies of all materials: workbook, PowerPoint presentations; and the survey. They attended a pilot of the one-day MC; provided feedback about the program; and trialled the evaluation tool. Their expertise was invaluable for the refinement of the developed program and evaluation tools in the WA context.

2.2 Implementation

The implementation phase commenced once the CPD program was developed, tested and modified. Implementation consisted of three distinct steps: (1) Pre-MC requirements: ethics and governance approvals, hospital nursing education department agreements, advertising at participating hospitals, establishment of a de-identified participant database after enrolments, and the usual education provider activities: room and equipment bookings, information to participants prior to the MC, arrangement of catering and so forth. (2) Delivery of MC and RPJ; including participant consent for research participants. (3) Data collection using survey and RPJ.

Sample

Participants self-selected to attend the MC. They were drawn from eight metropolitan hospitals. The program was delivered on seven occasions at five large metropolitan hospitals. A total of 159 nurses registered to attend the MC, of these registrants, 101 were able to attend the class with the majority of nurses stating they: were unable to attend due to lack of rostered time off: ward being too busy so leave was cancelled; asked to work an extra shift; study leave was not approved; and family crisis, for example ‘up all night with a

sick child'. Of the 101 MC participants 94 agreed to participate in the research; however, ten failed to meet the inclusion criteria because they failed to complete the post MC survey conducted directly after the MC. Complete data from eighty-four participants (84) were included in the research. Thirteen (13) of the 84 also participated in the RPJ component of the CPD program. The 13 RPJ participants submitted a total of 55 journal entries.

Table 1. Outline: CPD Program on caring nursing practice

Aims

1) Develop and deliver a CPD program on caring nursing practice that aligns with professional and social expectations of caring nursing practice in the context of competing health care paradigms.
2) Evaluate the extent to which a CPD program on caring nursing practice that can support caring nursing practice in Western Australian hospitals.
3) Make recommendations on provision of CPD programs supporting caring nursing practice in WA hospitals.

Assumptions

1) Caring is multidimensional with cognitive and attitudinal components.
2) The potential to care is present in all individuals.
3) Caring can be learned.
4) Caring is quantifiable. [31 p. 6]
5) Caring nursing praxis can be taught and developed.

MASTER CLASS (7.5 hours)

Objectives

1) Explore the concepts and contexts of caring nursing practice.
2) Determine what personal, professional, organisational and cultural factors that might impact the extent to which a professional development program can support caring nursing practice in WA.
3) Critically comment on theories and research on caring nursing practice.
4) Begin reflective practice about caring nursing practice.

Content

1) Recollection and self-awareness: reasons for entering the profession and remaining.
2) Concept analysis (nursing, caring & caring nursing practice): use of literature, research and socio-historical context.
3) Critical thinking: nursing approaches, scientific approaches, philosophical approaches.
4) Reflective practice: theory and application to participants nursing practice.
5) Cultural change: societal, health systems, professional, organisational, and individual.
6) Factors affecting caring.
7) Caring theory: place within nursing theory development.
8) Edges of science: mind-body connection and caring nursing practice.
9) Change & praxis.
10) Reflective Practice Journaling

Teaching/Learning Methods

Instructivist: Mini lessons: theory.
Constructivist: Concept analysis, development of personal definitions (care, cure, nurse, nursing, caring nursing practice, reflective practice, praxis); writing caring inventories; reflective practice (group and individual).
Direction: Continuum from teacher directed to student directed: use of - teaching presentations, group work and individual work.

REFLECTIVE PRACTICE JOURNALING (RPJ)

Objective

1) Reflect on the practice of caring practice clinical setting.
2) Engage with an educator skilled in reflective practice about both clinical practice, critical thinking and reflection and praxis.
3) Develop/deepen reflective practices skills.
4) Develop reflexive practice skills.
5) Develop/deepen clinical practice skills in caring.
6) Develop/deepen caring praxis.

Teaching/Learning Methods

1) Email submission of reflective practice journal entries over a six week period, post MC.
2) Educator feedback to participants.

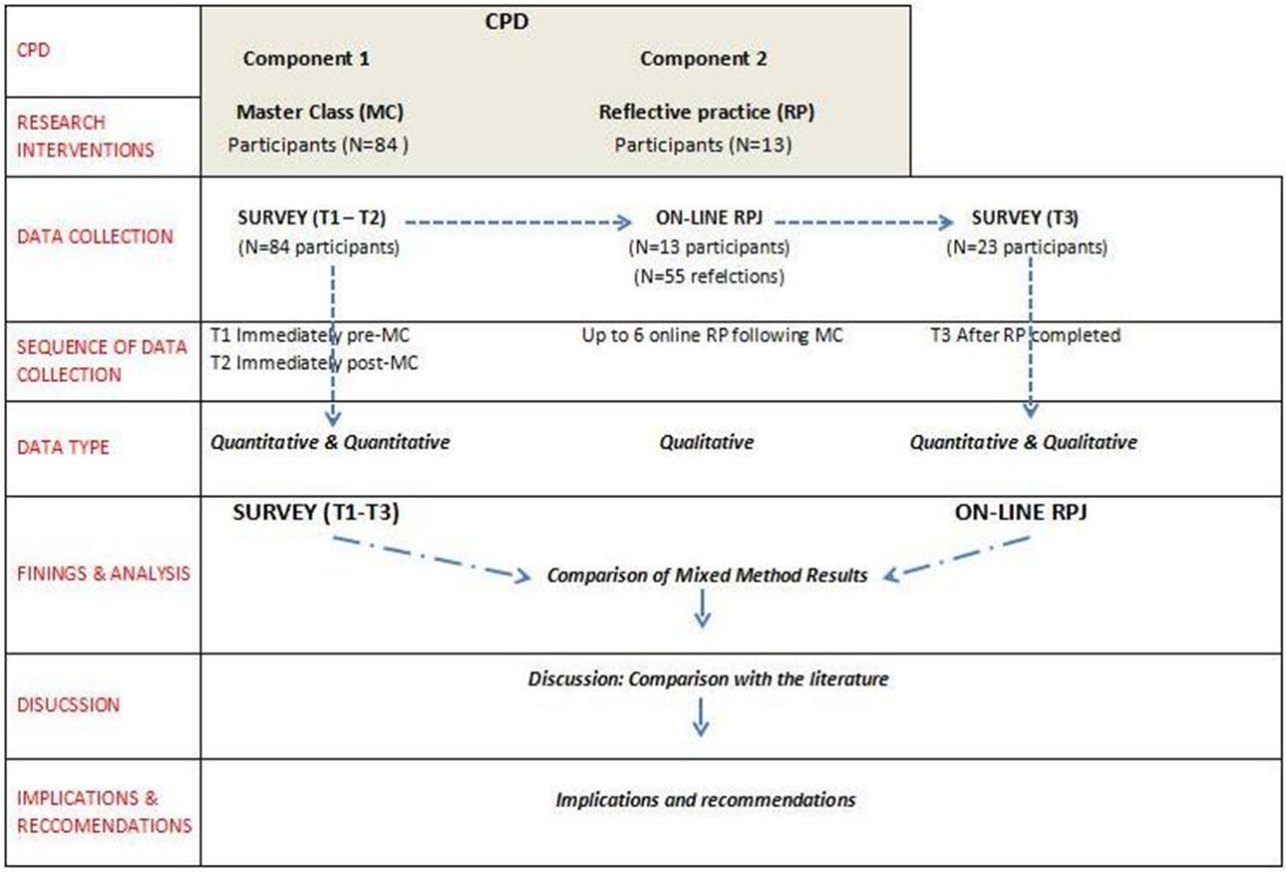

Figure 2. The evaluation plan

2.3 Evaluation and discussion

The philosophical stance for this research was eclectic. This is an approach which makes use of different philosophical traditions. The word eclectic is derived from Greek eklektikos – to be selectice. Philosophical eclecticism traces its origins to the Greek Academy 387 BCE – 529. Philosophical eclectisism was used throughout the research. The evaluation component of this research drew on pragmatism which allowed for analysis to utilise both quantitative and qualitative data in the study. Analysis and reporting took place between 2019 and 2020. The CPD program was evaluated after determining comparability of the sample with the broader population and in particular the population of the caring efficacy scale incorporated in the survey. Qualitative and quantitative survey data were entered in an excel spreadsheet. Qualitative data were analysed using descriptive statistics. RPJ submissions were copied from submitted email and collated in a single word document for analysis using standard thematic analysis techniques.[21]

2.3.1 *Results of the evaluation of the CPD program*

Evaluation of the CPD program using both qualitative and quantitative data is reported previously on the evaluation plan (see Figure 2):

(1) Survey data including data about (i) demographics, (ii) caring efficacy compared with an established caring efficacy scale[33] tested for reliability and validity of use in Australia,[34] (iii) personal emotions and motivations about nursing and caring, and (iv) knowledge learning gains,
(2) RPJ data and,
(3) Comparison of mixed method results: survey and RPJ data.

1) Survey data

(i) Data: Demographic

The demographics of the participants was similar to that of the general nursing population, except a slightly higher proportion of senior and executive nurses attending and less male participants. The number of senior and executive (SRN) nurses attending (N = 18%) were double those within the WA nursing population for typical government tertiary hospitals (N = 9.5%).[36] Men were under-represented at this CPD program (MC male nurses N = 2.4% versus Australian male nurses N = 9%).

There was a wide cross section of cultural heritages. Seventy nine percent of participants (N = 79%) stated caring was part of their religious/spiritual belief. As length of time

in nursing workforce increased, length of stay in a particular workplace tended to decrease. This finding also reflects Australian trends.[37]

Thirty five percent (N = 35%) of participants had a university post registration qualification with the vast majority of those qualifications being at post graduate level (N = 31%) compared with Australian figures (N = 13%).[37] There are no Australian figures about PG qualifications by individual professions.[37,38]

The MC attracted nurses from a broad cross section of practice areas ranging from mental health to intensive care specialists demonstrating that nurses across the breadth of nursing find caring to be a component of their care.

(ii) Data: Caring efficacy

The Caring Efficacy Scale (CES) results were similar to those reported in the Australian CES.[34] CES scores across the three time frames were high. There was a minimal increase in these scores over the three time periods. This indicates the CPD did not make a difference to caring efficacy in this cohort of nurses who already scored high on the CES.

(iii) Data: Emotions and motivations about caring and nursing

Data were collected about the emotion of being 'uplifted' and motivations to (i) come to work (ii) continue in nursing (iii) care. This data was used to determine if the MC made a difference in these areas. Nurses found nursing emotionally uplifting (Mean 3.8 on a 5 point Likert scale) across three time frames. There were many intrinsic and extrinsic factors motivating nurses to stay in their careers and to care.

Table 2. CES scores T1-T3

	Mean	SD	Range	% of participants with perceived CE score
REID[24]	5.074	0.497	3.470-6.000	100% (> 3.0)
T1	4.792	0.306	3.259-5.296	100% (> 3.0)
T2	4.870	0.247	4.414-5.354	100% (> 3.0)
T3	5.051	0.331	4.444-5.667	100% (> 3.0)
All	4.904	0.133	4.792-5.051	100% (> 3.0)

(iv) Data: Knowledge learning gains

Knowledge about: nursing, caring, healing and curing, nursing in hospitals, and knowledge about thinking were surveyed and demonstrated learning gains after the MC. Context learning gains across the five knowledge groupings were evaluated. Quantitative learning gains are represented numerically and qualitative learning gains determined by thematic analysis are represented with a ✓ (see Table 3).

Each of the five groupings are discussed separately below. Definitions were assessed against a marking rubric for each definition to provide quantitative results. The rubric included criteria related to the definitions. A score was given based on the number of criteria the participant included in their definition. These scores were then used to determine learning gains. A description of the findings is based on the number of times a particular criteria was mentioned in a definition and additional analysis of qualitative comments provided by participants.

Nursing and caring

Nursing and caring definitions showed caring nursing practice was seen as something that went beyond technical nursing practice and caring was seen to be the demonstration of attributes and values and the disposition of the nurse as well as technical competence. Participants recognised an holistic approach to care which views the patient as an individual with a variety of health needs within hospital and family contexts. There were both qualitative and quantitative knowledge gains about caring and nursing.

Healing and curing

Participants entered the MC with an understanding that the mind is involved in healing and curing. The concept of mind-body connection and how to positively influence the connection was enhanced by the MC. There was recognition that each member of the interprofessional team had a role to play in supporting caring and supporting caring nursing practice. The distinctions between heal and cure was also enhanced by the MC.

Nursing in hospitals

All participants identified a variety of means by which hospitals are able to support caring nursing practice even though organisational understanding varied among participants. Participants provided up to three responses at each time interval in response to what their hospital could do to support caring nursing practice. In total there were 486 responses over the three time frames which fell into eight groupings (see Table 4).

Thematic analysis of the qualitative component of responses demonstrated the emotional attachment to comments were not the same for each group. Comments in the lead by example groups evoked highly emotive responses: 'live up to the hype they propound in their mission statements by actually caring for their employees', 'Engage in and understand what nursing is like on the floor rather than from the balcony!', and 'Loose the corporate approach – accept that health care is a service not a business' and 'be less dictatorial'. These comments were often linked to calls for the hospital to 'Listen!' to nurses – 'the bedside', 'actually visit areas, meet staff, be available', and 'let staff be involved in decision making'.

Table 3. Knowledge areas surveyed and learning gains

Knowledge areas	Learning gains after MC		
	Qualitative	*Quantitative*	
		T1	T2
1 NURSING			
Definition of nursing – including caring		68%	68%
Socio-historical factors impacting nursing and nursing education	✔		
Nursing theory related to evidence-based practice and critical thinking	✔		
2 CARING			
Definitions of caring; "caring nursing practice"; a "caring moment"	✔		
Personal factors influencing caring	✔		
Behaviours that demonstrate caring nursing practice	✔		
Benefits and importance of caring: patient, nurse, organisation, nursing profession, society		85%	95%
Theories of caring: science of caring and caring science	✔		
3 **HEALING - CURING**			
Definition of cure	✔		
Definition heal	✔		
Distinction between cure and heal		82%	93%
The mind is involved in healing/cure		99%	99%
Meaning of mind-body connection	✔		
Positively influencing mind-body connection	✔		
4 NURSING IN HOSPITALS			
Hospital support for caring nursing practice (caring nursing practice)	✔		
Effect of caring nursing practice on organisations		97%	97%
5 THINKING			
Nursing models: critical thinking - scientific thinking process		18%	67%
Definition of praxis		6%	72%
Activity which might enhance praxis		15%	73%
Definition of reflective practice		95%	93%
Steps of reflective practice		76%	92%
Benefits of reflective practice		92%	93%
Learning takes time		92%	94%

Table 4. Hospital support for caring nursing practice

		T1 % N = 220	T2 % N = 214	T3 % N = 52
1	Leading by example	17.0	15.0	30.8
2	Leading by commitment	27.4	30.3	25.0
3	Support for nurses and nurses supporting CNP	14.5	12.6	11.5
4	Physical environment	1.0	1.9	7.7
5	Workplace culture	3.6	3.3	3.8
6	Human resource management	6.4	7.9	7.7
7	Modification of Practice	6.0	10.3	7.7
8	Provision of education	24.1	18.7	5.8
		100	100	100

The MC increased the perceived effects of the physical environment on patients and staff, and the perceived effects of leadership support for nurses. Opportunities for caring nursing practice were linked with leaders ability to lead by example and commitment. The MC altered the importance nurses attributed to what their hospitals could do to support caring nursing practice. For example, the perceived importance and effect of education on caring nursing practice decreased after the CPD program whilst the perceived effect of leadership increased.

Thinking

After the MC there were learning gains in knowledge about critical thinking and reflective practice. Teacher/researcher observations during the MC showed participants were comfortable discussing 'evidence-based practice' but not as comfortable with what constituted critical thinking as it applied to evaluating the quality of research evidence or its application to reflective practice. There were learning gains in knowledge about ways of thinking - including structured critical thinking as distinct from scientific thinking. Survey data demonstrated most participants strongly agreed that learning takes time.

Praxis as opposed to practice, was poorly understood prior to the MC (T1-6%). There were marked learning gains after the MC (T2-72.6%). There was an understanding of what constituted reflective practice and benefits of reflective practice also increased after the MC. Formal knowledge about steps which might be used in reflective practice increased, after the MC. Participants were not familiar with concepts of reflexive reflection prior to the MC and this was not altered by the MC. Benefits of reflective practice were understood and this increased after the MC.

2) Data: RPJ

Reflective practice journaling provided additional benefits. The number of completed RPJ submissions varied between participants (see Table 5).

Table 5. RPJ participation

Number of reflections	Number of participants	Total number of RPJs submitted
6 or more	5	38
5	2	10
2	1	2
1	5	5
	13 participants	55 reflections

Those who did not complete RPJ provided reasons. These reasons fell into three groupings: "starting a new position/leaving current position"; "life has become too chaotic/difficulty finding the time and space"; and "struggling with personal/family problems".

Five themes and one meta-theme emerged from coding and the thematic analysis of RPJ submissions:

(1) Satisfaction: the importance of satisfaction; lack of satisfaction related to inability to provide caring nursing and its impact on increased sick leave and attrition.

(2) Values: internalised values were used by participants to measure to their own caring nursing practice and perceived values of the organisation. For example one participant stated "What adds to this difficulty is system pressures and values, I often feel the system does not acknowledge or reward caring practice. There is an over-focus on meeting time, efficiency and task orientated targets."

(3) Time to nurse had four sub themes: (i) inadequate time to care for the body; (ii) inadequate time to care for both mind and body; (iii) inadequate time to care for complex, mixed, and variable patient loads; (iv) inadequate time to develop practice; and time to care for oneself.

(4) Conflict and the role of the nurse: Conflict came from a need to perform: in different health care roles, on different campuses, and work within an hierarchical hospital structure resulting in conflict between health professionals and between different levels of the hierarchy.

(5) Capacity to provide care: Capacity to provide caring nursing practice were reportedly impacted by: aspirations for career progression, burnout, a sense of isolation and lack of support for sustained provision of care. There were personal consequences for persevering with nursing as a career. Images of a sometimes violent and challenging work environment emerged.

(6) The balancing act of patient care. The balancing act of patient care emerged as a meta theme. It found expression in participant's satisfaction or lack of satisfaction about perceived capacity to carry out what they consider to be their core business: caring for patients. Participants considered: values, time to nurse, role conflict, and capacity to provide care as impacting their level of satisfaction about their ability to care for patients. Satisfaction was based on shared understandings about what constitutes caring nursing practice rather than idiosyncratic and individualistic views. So, for nurses in this research, caring for the patient required a balancing act (see Figure 3).

Participants felt that the locus of control/responsibility for caring nursing practice remained with nurses. However, when discussing what to do when confronted by competing pressures on caring nursing practice they indicated that they perceived their 'agency' to be low. They felt they had little ability to impact caring nursing practice at an organisational or health system level. They stated that although they may

have an impact at the ward or unit level anything more than this was largely out of their control. This finding was surprising given the proportion of senior nursing staff attending the CPD was double the proportion of senior nursing staff in a typical government tertiary hospital. RPJ did affect understanding and opinion about locus of responsibility for caring nursing practice but not opinions about agency.

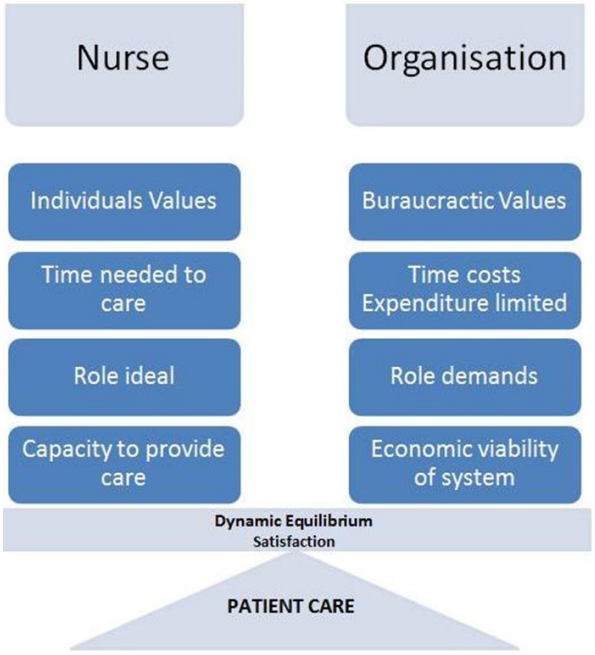

Figure 3. Balancing act of patient care

RPJ data strongly indicates that balance does not exist. That the role ideal of caring nursing practice is not a reflection of the role demands of the organisation. Data indicated that the foundation values held by nurses in this study was at odds with the bureaucratic values of the organisations and this resulted in a reduced capacity to care at the expense of economic viability of the system.

From an education perspective there was a demonstrable additional value of RPJ on critical thinking. Over the duration of RPJ there was an increase in the number of RPJ participants who demonstrated reflexivity. Of 51 submissions which demonstrated critical thinking reflexivity was ultimately achieved in 36% of submissions.

It was found that RPJ could support the integration of content knowledge in practice and for some it could also support praxis.[39,40]

3) Data: Comparisons

There were three data comparison activities: (1) survey and RPJ data (2) research data and with findings in the literature. (3) this research and education research in the field.

Survey and RPJ data were congruent in their findings related to: caring efficacy; emotions and motivations about caring and nursing; and learning gains. RPJ data provided additional opportunity for participants to engage with MC content knowledge and enhance aspects of MC learning gains. In particular, RPJ appeared to support deepening understanding of caring nursing practice and of the benefits of critical thinking an of reflective practice.

When compared with the literature this research appears to support current theory, research and public perceptions:

(1) Emotions and motivations to nurse, appear to link caring and nursing.
(2) Participants understood organisation and popular expectation that 'nurses should care'.
(3) Caring nursing occur within a health care system with conflicting paradigms which results in personal and organisation level pressures about role expectations and role demands of the nurse.
(4) Recognition that cooperation within the interprofessional team is required for each profession to maximise caring capacity.
(5) Caring efficacy is high while caring agency is low in nurses.

From an educators perspective, there is little in the education or evaluation literature which provides sufficient detail with which to compare and assess the development of this curriculum. Its value lies in its demonstrated capacity to address an unmet need in the support of caring nursing practice.

3. Discussion

The evaluation of the curriculum was comprehensive and provided much needed evidence-based data for a CPD program of this nature.

This research clearly demonstrates that: caring can be taught; a curriculum which aims to move participants from basic content knowledge about caring through to caring praxis is possible; and that the context of that curriculum within the health care system has an effect on the efficacy of the curriculum.

In particular it demonstrates nurses perceptions about competing paradigms within the WA health care system and a perceived need for interprofessional caring at all levels of the system.

A key finding was that caring-efficacy (perceived ability to implement caring nursing practice) was high while participant perceived caring agency (their perceived ability to act to influence caring) was low resulting in a variety of individual responses to the stress associated with the balancing act of

caring.

The main limitation to this study was that participants self-selected.

4. Conclusions & recommendations

This research demonstrated that a CPD program can produce learning gains in: (1) knowledge, (2) critical and reflective thinking, and to a lesser extent (3) praxis. However, these gains are limited by the organisational, professional and cultural context in which they operate.

The ethical and moral dilemma for each one of us and for society as a whole, with regards to nursing and the role of health care is - How do we support caring nursing practice? Education may be one way, but the effectiveness of this support is constrained by other factors which need to be addressed.

The recommendations:
1) Integrate, as a priority, the CPD program, the value of caring practice, and time to implement and reflect on caring practice, into a whole of system approach to a collaborative interprofessional caring culture at all levels of the health care system.
2) Prioritise resources to develop, implement and evaluate a CPD 'train the trainer' program to assist in widespread ongoing dissemination of education on caring.
3) Provide paid access to a CPD program on caring practice to all professions.

5. Translation to practice

An Executive Summary of this research was provided to the WA Minister for Health, the Australian Medical Association, The Australian Nursing Federation, Executive Management at all participating hospitals and the WA Office of the Chief Nurse. Results and recommendations were presented in person by the researcher to the WA Nursing Executive at the WA Chief Nurse and Midwifery Office.

Conflicts of Interest Disclosure

The authors declare that there is no conflict of interest.

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