EDITORIAL BOARD
Editor
Zane Robinson Wolf, PhD, RN, FAAN
Dean Emerita and Professor, School of Nursing
and Health Sciences,
La Salle University,
Philadelphia, Pennsylvania, USA

Marion C. Turkel, PhD, RN, FAAN
Editor, Book Review and Continuing Education,
Director of Professional Nursing Practice Research,
Einstein Healthcare Network,
Philadelphia, Pennsylvania, USA

Charlotte Barry, PhD, RN
Assistant Editor, Essays,
Professor,
Christine E. Lynn College of Nursing,
Florida Atlantic University,
Boca Raton, Florida, USA

Nancey France, PhD, RN
Assistant Editor, Book Review,
Continuing Education and Curriculum,
Associate Professor,
Christine E. Lynn Center for Caring,
Florida Atlantic University,
Boca Raton, Florida, USA

Kathleen L. Sitzman, PhD, MS, RN
Assistant Editor
Professor, Nursing Department,
East Carolina University,
Greenville, North Carolina, USA

EDITORIAL ADVISORY BOARD
Anne Boykin, PhD, RN
Emerita Dean, College of Nursing,
Director, Christine E. Lynn Center for Caring,
Florida Atlantic University,
Boca Raton, Florida, USA

Chantal Cara, PhD, RN
Vice Dean, Professor,
School of Nursing,
University of Montreal,
Montreal Quebec, Canada

Joanne R. Duffy, DNsC, CCRN
Professor, Indiana University,
Indianapolis, Indiana, USA

Katie Eriksson, PhD, RN
Professor, Department of Caring-Science,
Abo Academy University,
Vasa, Finland

Dawn Freshwater, PhD, BA, RGN, RNT, FRCN
Head of School, School of Healthcare Studies,
University of Leeds,
Leeds, United Kingdom

Sigridur Halldorsdottir, RN, PhD, Med. Dr.
Professor, Director of Graduate Studies,
Faculty of Health Sciences,
University of Akureyri, Iceland

Jane Hsieh, MSN, RN
Professor,
Nursing Department,
National Taipei College of Nursing,
Taipei, Taiwan

Patricia L. Munhall, EdD, ARNP, PsyA, FAAN
Miami, Florida, USA

Forough Rafii, PhD, RN
Associate Professor, School of Nursing &
Midwifery
Tehran University of Medical Sciences
Tehran, Iran

Maj-Britt Råholm, RN, PhD
Professor/Head of Research and Development,
Stord/Haugesund University College,
Faculty of Health,
Haugesund, Norway

Marilyn A. Ray, RN, PhD, CTN-A
Emeritus Professor,
Christine E. Lynn College of Nursing,
Florida Atlantic University,
Boca Raton, Florida, USA

Sr. M. Simone Roach, PhD, CSM, RN
Writing/Research and Director,
Heritage Center, Sisters of Martha,
Antigonish, Nova Scotia, Canada

Gwen Sherwood, PhD, RN, FAAN
School of Nursing, University of North Carolina,
Chapel Hill, North Carolina, USA

Savina O. Schoenhofer, PhD, RN
Professor,
Alcorn State University,
Natchez, Mississippi, USA

Christine E. Lynn College of Nursing,
Florida Atlantic University,
Boca Raton, Florida, USA

Kathleen Valentine, PhD, RN
Director, Memory and Wellness Center,
Christine E. Lynne College of Nursing,
Florida Atlantic University,
Boca Raton, Florida, USA

Jean Watson, PhD, RN, AHN, BC, FAAN
Founder and Director,
Watson Caring-Science Institute,
Boulder, Colorado, USA

EDITORIAL REVIEW BOARD
Siv Bäck-Pettersson, PhD, RNT, RN
Director of Research,
R&D Departments,
NU Hospital Group and
Primary Health Care Fyrbodal,
Trollhättan/Vänersborg, Sweden

Denise Nagle Bailey, EdD, MEd, MSN, RN, CSN
Assistant Professor, School of Nursing and
Health Sciences,
La Salle University,
Philadelphia, Pennsylvania, USA

Diane M. Breckenridge, PhD, RN, ANEF
Associate Professor,
La Salle University,
School of Nursing and Health Sciences,
Philadelphia, Pennsylvania, USA

Diane Buchanan, RN, DNSc
Assistant Professor, School of Nursing,
Queen’s University,
Kingston, Ontario, Canada

Esther Condon, PhD, RN
Professor, School of Nursing,
Hampton University,
Hampton, Virginia, USA

Florence Neely Cooper, BSN, RN, CNOR
RN Educator, Perioperative Services
University of Mississippi Health Center
Jackson, MS, USA

Sharon Ann Cumbie, PhD, RN, CS
Associate Professor, College of Health Sciences,
Appalachian State University,
Boone, North Carolina, USA

Lisa Davis, PhD, RN
Associate Professor, School of Nursing,
West Texas Agriculture and Mining University,
Canyon, Texas, USA

Charlotte Delmar, PhD, MSc Nursing,
Research Director in Clinical Nursing,
Aalborg Hospital,
Aalborg, Denmark

Dorothy J. Dunn, PhD, APN, FNP-BC, AHN-BC
Assistant Professor,
School of Nursing,
College of Health and Human Services,
Northern Arizona University
Flagstaff, AZ, USA

Philip Esterhuizen, PhD, RN
Senior Lecturer,
School of Healthcare,
University of Leeds,
Leeds, United Kingdom

Dorothy K. Fischer, RN, PhD
Professor,
Wilmington University,
Wilmington, Delaware, USA

Wrennag Gabbert, PhD, RN, MSN, CPNP, FNP-C
Associate Professor,
Anita Thigpen Perry School of Nursing
Texas Tech University Health Sciences Center
Lubbock, Texas, USA

2013, Vol. 17, No. 3
CONTENTS

EDITORIAL 6
Zane Robinson Wolf, PhD, RN, FAAN
The Making of a Butterfly: Reflective Practice in Nursing Education 7
Jessalyn F. Barbour, MSN, RN, OCN
The Lived Experience of BSN Students in Caring Groups: Priceless 13
Carol B. Wilson, PhD, RN
Kathryn Grams, PhD, RN
Becoming Whole: Kari Martinsen’s Philosophy of Care – Selected Concepts and Impact on Clinical Nursing 20
Charlotte Delmar, PhD, MSN, RN
Designing a Fourth Year Baccalaureate Nursing Course Utilizing the Lens of The Theory of Bureaucratic Caring and a Root Cause Analysis Approach 29
Colleen Maykut, RN, DNP
Lisa McKendrick-Calder, RN, MN
Mentoring Clinical Adjunct Nursing Faculty 35
Mary Lou Gies, EdD, MSN, RN

Abstracts from the 34th International Association for Human Caring Conference 41-101
Keynote Presentations 42-43
Symposia 43-49
Podium Presentations 49-77
Posters 77-93
Caritas Posters 93-97
Student Posters 97-101
Editorial
Zane Robinson Wolf, PhD, RN, FAAN

This issue of the International Journal for Human Caring (IJHC) includes several articles. The works of Jessalyn F. Barbour, MSN, RN, OCN, Carol B. Wilson, PhD, RN and Kathryn Grams, PhD, RN, Charlotte Delmar, PhD, MSN, Colleen Maykut, RN, DNP and Lisa McKendrick-Calder, RN, MN, and Mary Lou, Gies, EdD, RN stand out. The issue also highlights the International Association for Human Caring’s (IAHC’s) 34th Conference presented at Walt Disney World Swan and Dolphin Resort, Epcot Resorts Boulevard, Lake Buena Vista, FL, USA. Attendees from across the world converged on Orlando, Florida to enjoy symposia, podium speeches, and different poster sessions. Many students and mentors showcased beginning and established scholarship. Next year, the conference will be held in Japan. The flyer for the conference is included in this issue of IJHC.

Synthesis Challenge
I am challenging members of IAHC and the readers of IJHC to write articles as a synthesis challenge. This challenge originates in the conviction that it is time to analyze extant literature on caring and care through metasynthesis and metaanalysis approaches. This is the second time IJHC has issued such a challenge.

The idea for the synthesis challenge began with a discussion by the members of the Synthesis on Caring and Related Constructs Committee of the Anne Boykin Institute for the Advancement of Caring. Committee members are: Sharon Dormire, sdormire@fau.edu; Rozzano Locsin, locsin@fau.edu; Joy Longo, jlongo5@fau.edu, and me, Zane Robinson Wolf, wolf@lasalle.edu.

The call for synthesis articles begins now and manuscripts will be reviewed for IJHC’s Special Topics issue, 19(2) 2015. Manuscripts should be sent electronically to me at wolf@lasalle.edu by September 30, 2014.

Various articles are available in literature on systematic reviews and other approaches to literature synthesis. The following article presents the variety of such reviews:


Erratum

One reference was omitted: Gabrielsen, E., Näden, D., Lindström, U. A., (2007). Do patients receive care if they are perceived as patients able to cope? Holistic Nursing Practice, 21(2), 65-71. Also, see page 65, column 1, sentence a from the heading “Background.” The sentence in the published article is: “Searching in Academic Premier we located a study of this kind.” The sentence is should read: “Searching in Academic Search Premier we did not find a study of this kind.”
The Making of a Butterfly: Reflective Practice in Nursing Education
Jessalyn F. Barbour, MSN, RN, OCN
Notre Dame of Maryland University

Abstract
Reflective practice is the cyclic process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, existing knowledge, and experience. This is a descriptive phenomenological study that explores the guided reflections of eighteen RN-to-BSN students. The themes derived from the student text include (a) reflection in-action; (b) reflection on-action in daily nursing practice; (c) time, autonomy, experience, and fear were identified as barriers. By integrating reflective pedagogies into nursing curriculum, nurse educators can help students develop competence in reflective practice and enhance their learning for a lifetime.

Key Words: reflective practice, reflective pedagogies; RN-to-BSN students, nursing education

The Making of a Butterfly: Reflective Practice in Nursing Education
A butterfly gracefully flutters from one flower to the next, taking nectar from each flower, but also leaving pollen behind. Imagine the expert nurse effortlessly floating around the unit, meeting the needs of the patients with her knowledge and intuition and prepared for any setback. The expert nurse gains a bit of knowledge with each patient cared for, taking a piece of the experience with her, while leaving a part of herself with the patient in the holistic care provided.

Nursing is truly a work of art that requires a balance of many ways of knowing at once. The transformation of the caterpillar to butterfly or student to nurse is part of a process. The nursing student learns and experiences the nursing world through classroom and clinical education. The student goes to a safe and comfortable place to reflect on and explore self, newly gained experiences, and knowledge. Eventually, with time, reflection, and practice, the student nurse will evolve into a nurse. Therefore, the question becomes, what is the nurse educators’ role in this transformation and in what ways might we assist in this journey? This paper explores the phenomenon of reflective practice in RN-to-BSN students. With reflective practice being the cocoon in which nursing students truly mature and prepare to spread their wings.

What is Reflective Practice?
There are different epistemologies and ontologies in reflective practice. Reflective practice was first documented with the work of Greek philosopher, Socrates. Socrates would lead exploratory discussions, in which a group or person would examine their knowledge on a topic and their personal beliefs about it. This technique is still used in many classrooms and is known as Socratic discussions (McEntee et al., 2003). Socrates’ most famous student, Plato, continued this philosophical inquiry by urging students to perform ontological investigations by questioning their ideas and values (Kuiper & Pesut, 2004). In the nineteenth century, Florence Nightingale wrote her reflections on nursing, thereby, introducing reflective practice to the nursing profession and forever changing it (LaSala, 2009).

Reflective practice goes beyond the revisiting of an event by taking the practitioner on a journey of self-discovery to become a better practitioner (McEntee et al., 2003). This journey allows for the exploration of knowledge, skills, values, beliefs, experiences, myths, and needs that ultimately lead to clarified conceptual meanings and heightened self-awareness (Asselin, 2011; Durgahoe, 1997; McEntee et al., 2003; Palmer, Burns, & Bulman, 1994). Reflective practice can be a form of self-assessment (Cook, 2011). Reflective practice can also be a spontaneous action wherein the nurse pauses to consider a decision regarding patient care, in what Watson (2008) calls “caring consciousness” (Palmer et al., 1994).

Reflective practice is the cyclic process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, existing knowledge, and experience; resulting in a changed conceptual perceptive and practice (Asselin, 2011; Beam, O’Brien, & Palmer, 1994). Palmer et al. (1994) and Beam et al. (2010) suggest the use of Gibb’s reflective cycle (Figure 1) to guide students’ reflections (Gibbs, 1988). Gibbs (1988) uses the reflective practice process as a guide for experimental learning. For the purposes of this study, a form of guided reflective practice was used, in which reflective thoughts are articulated in words, either written or verbal, with the assistance of guiding questions or other tools.

Reflective Practice in the Literature
Critically thinking is an essential skill for a nurse. In the fast-paced nursing world, nurses need to be able to think-on-the-fly and be confident in their decision-making. Nurses must have the courage to nurse and...
The Making of a Butterfly: Reflective Practice in Nursing Education

to question the status quo. Every novice nurse dreams of being Benner’s (1984) expert nurse, who floats through the day and can think-on-the-fly to make decisions with no disruption of care. Reflective practice is a powerful process that contributes to the making of a quality, expert nurse. Reflective nursing practice empowers nurses in both the educational and professional realms.

There are numerous benefits of reflective practice. Reflective practice provides experiential learning opportunities (Benner, Sutphen, Leonard, & Day, 2010; Palmer, et al., 1994). A qualitative study of eight nursing students showed that reflective practice enhanced learning (Bradbury-Jones, Hughes, Murphy, Parry, & Sutton, 2009). Another study evaluated the effects of a reflective practice bachelor of science in nursing (BSN) curriculum model, which resulted in National Council Licensure Examination (NCLEX) pass rate of greater than 95% (Walker, Tilly, Lockwood, & Walker, 2008). Being able to self-teach is an important skill to have in the nursing profession. The use of reflective practice in education can assist nursing students to learn from practice and to self-teach so that they are better able to meet the challenges of the professional nursing world (Benner et al., 2010).

Reflective practice assists in the cultivation of critical thinking skills in students (Benner et al., 2010; Cook, 2011). It has the ability to strengthen Carper’s (1978) four patterns of knowing: empirical, esthetical, personal, and ethical knowledge (Davis, Taylor, & Casida, 2011). Reflective practice prepares the nurse to ask the right questions in the clinical practice setting and notice slight changes in their patient’s status (Picard & Henneman, 2007). Furthermore, reflective practice can improve communication skills in nursing students (Durghaee, 1997).

Reflective practice is a journey of self-discovery that leads to better practitioners (McEntee et al., 2003). A study by Bradbury-Jones, et al. (2009) shows an increase in students’ self-awareness after the implementation of reflective practice. Reflective practice increases the likelihood of the nurse providing ethical and holistic care (Gustafsson, Asp, & Fagerberg, 2007). A study on the use of reflective practice in surgical nurses shows a positive correlation between reflective practice and authentic nurse-patient relationships (Flanagan, 2009). Reflective practice cultivates presence, which is an essential element of relational engagement with patients (McMahon & Christopher, 2011; Picard & Henneman, 2007) and leads to more individualized nursing practice (Flanagan, 2009). A study that examines the effects of reflective practice on RN-to-BSN students shows that it changed the nurses’ practice perspectives and actions (Asselin, 2011).

Reflective practice can be used to help bridge the theory-practice gap by encouraging examination, exploration, and connections (Benner et al., 2010; Davis et al., 2011; Smith & Jack, 2005). Reflective practice has the potential to decrease stress in nurses’ professional lives (Palmer, et al., 1994) and promotes integrity, balance, and morality (Bjarnason et al., 2009). It has been shown to promote the development of intuition, which is the essence of the expert nurse (Benner, 1994; Hannigan, 2001).

While reflective practice can be a beneficial tool and process, it also has limitations. There is limited research on reflective practice in nursing education in the United States. There are also barriers involving students and reflective practice. Some students are not open to the idea of reflective practice (Benner et al., 2007; Kuiper & Pesut, 2004). They feel vulnerable exposing their thoughts and feelings to others, they feel uncomfortable with their

![Figure 1. Reflective Practice Cycle (adapted from Gibbs, 1988)](image-url)
own emotions, and/or they are satisfied with their current level of competence (Asselin, 2011; Benner et al., 2010; Kuiper & Pesut, 2004). Time is a major barrier for nurses and students to practice reflective practice (Beam et al., 2010; Bradbury-Jones et al., 2009; Picard & Henneman, 2007; Smith & Jack, 2007).

Exploration of RN-to-BSN Students Use of Reflective Practice
A nursing student’s educational journey can be enhanced with reflective practice, both spontaneous and guided. In addition, reflective practice in the nurse can improve practice. So the question becomes, do RN-to-BSN students use reflective practice? How do they use it? What obstacles do they encounter that discourage reflective practice?

Study Design
This is a descriptive phenomenological study.

Study Setting
The study took place at a private university in Baltimore, Maryland.

Study Sample
The sample included 18 RN-to-BSN student essays from two accelerated contemporary nursing trends and theory courses.

Study Procedure
Week two of six in the contemporary nursing trends and theory course was an online class. It consisted of a slideshow presentation on the Nursing Code of Ethics and various activities, all to be completed within one week. One of the activities was to read an article on reflective nursing practice and then answer the following questions in a one-to-two page essay:

(a) In what ways do you engage in reflection about your nursing practice? Tell a story or two using rich descriptive language where you show reflective practice and what it means.

(b) In your experience, what allows for and what gets in the way of reflective practice?

Gathering of Student Text
The participants submitted typed essays that were a response to the above questions. The essays were not graded, but were a pass/fail type item for participation in the online class.

Interpretation of Student Text and Text Analysis
The essays were reviewed and themes were derived. Themes were validated by a doctorate-prepared research consultant and the study participants.

Results
Three major themes were identified from the student text. Only the essays examining the previously mentioned questions were included (n=18).

Theme A: Nurses reflecting in-action/thinking-on-the-fly
Most (n=16) of the nurses in this study describe what Schön (1983) calls reflection in-action. The nurses describe situations in which they reflected while working and make decisions and/or changes based on these reflections. These nurses think-on-the-fly and make decisions on the go. Many of these nurses are experienced nurses who have been in the nursing profession for years and describe a time when they were less able to perform reflective practice and less confident in their decision-making abilities. Jane states, “As a newer nurse, engaging in reflection, happened after the experience occurred.” Jane went on to explain that with experience she was able to reflect while the experience was happening, think-on-the-fly.

The majority of the reflections in-action revolves around ethical or moral issues and the nurses dealing with difficult situations. Some (n=4) describe asking themselves, “How would I like to be treated if I were the patient?” These reflections led to decisions in which the nurses advocate for their patients. These reflections also allow the nurses to provide more individualized patient care. A few nurses discuss the exploration of their feeling while in-action, which allow for improved decision-making.

Reflection in-action is also used by the nurses to help them prioritize. Many claimed that this ability came with experience. Some nurses even describe reflecting with their peers throughout the work day. This collegial support aided them by increasing their confidence in their decision-making abilities.

A number of the nurses (n=4) stated that reflection in-action allowed them to link theory to practice. Many described the application of theory into their daily practice and the solidifying of theory when they actually saw it in action. Shari describes her nursing education and states that “during clinical rotations, things began to become clearer and all the textbook knowledge became significant” once it was seen in action.

Theme B: Nurses reflecting on-action/retrospectively
All (N = 18) of these nurses practice reflection on-action, which is the examining of an event after it has occurred (Schön, 1983). This type of reflection does not appear to be related to experience. Many nurses also use this method to deal with ethical or moral issues. However, this retroactive reflection rarely changed the event reflected on, but rather allowed the nurses to make changes to their practice and methods in the future. Reflection on-action allowed the nurses to change and improve their nursing practice. They describe being able to learn from experience. Amy describes reflective practice as “simply learning from my experiences and providing the best possible care based on those experiences…I reflect to grow professionally and personally.”

Reflection on-action allows these nurses to examine themselves and explore their feelings. This produces a self-awareness and confidence within the nurses. Self-
assessment allows the nurses to make appropriate changes and to be aware of their limitations in practice. Reflection on-action allows the nurses to have a more holistic and open-minded view. Many nurses discuss the concept of authentic nurse-patient relationship and the importance of their presence in their patients’ care. Mary states, “I will remember that patients and their families need us so the pumps can blare, and the phones can continue to ring.” Mary discusses the importance of just being there for her patients when they need her and not allowing tasks to get in the way. Some even state that this action helps prevent burn-out syndrome. All of these products of reflection on-action lead to higher quality and more holistic nursing care.

**Theme C: Barriers**

One obvious barrier is experience; practice makes perfect. Those nurses with more experience were better versed in reflective practice. Other barriers include: fear of emotions and self-exploration; time; and lack of autonomy.

Time appears to be the most common obstacle for nurses trying to engage in reflective practice. Many described a fast-paced and hectic environment in which they had no time for reflective practice. Others described heavy workloads and high acuity patients, which left little time for anything else. High nurse-patient ratios were also mentioned as a barrier to reflective practice. A few nurses report that having to perform multiple roles and being pulled in many directions was time consuming and left little time for anything else. Bethany states, “New technology and experimental life sustaining techniques also add a complexity to caring for our patients that leaves little time for reflection.”

Another barrier that is frequently mentioned is the lack of autonomy in nursing. Many of the nurses in this study feel that policies and procedures dictate how they practice; they feel restrained by organizational rules and regulations. Allison said, “With so many rules and regulations that require enormous amounts of time spent on documentation, it is not hard to see why many nurses have become so focused on completing tasks in nursing and lose sight of the caring aspect nursing was founded on.” This leads into another barrier that the nurses discuss, nursing’s obsession with tasks and documentation, which takes the focus off the patient, caring, and reflective practice. Lastly, the nurses discuss the lack of autonomy due to administration and physicians. These limitations and barriers can be hard for nurses to overcome, especially when they are inexperienced and lack the tools needed for reflective practice.

**Discussion**

It is well known that the gaps between theory and practice in nursing need to be bridged and that a curriculum revolution in nursing education is underway. In order for nursing education to produce holistic nurses, its curriculum must be balanced. One possible way to aid in this journey is the use of reflective practice.

This study has shown that practicing nurses in a RN-to-BSN program use reflective practice on a daily basis. This skill has aided them in many ways. It allows nurses to learn from experience and make changes to their practice to provide higher quality care. Reflective practice assists the nurse to be truly present and aware of themselves and the patients they care for. It promotes the unification of theory and practice. Reflective practice supports nurses in being morally and ethically sound in their care. It encourages continued growth by way of self-assessment and self-awareness. Lastly, it fosters a more holistic nursing approach.

Reflective practice should be taught during nurses’ initial education. It is an important and valuable skill to have. Reflective practice should be used and developed throughout the nursing program curriculum, that way the novice and beginning nurses are able to use it immediately upon entering practice. “The process of learning to learn from experience is as important as the end product of the learning, namely an ability to view a phenomenon from a different perspective and translate new knowledge into action (Palmer, et al., 1994).” Learning to learn is a valuable gift that nurse educators can bestowed upon nursing students to use in the rapidly changing nursing world.

**Implications for Practice**

There are numerous ways that reflective pedagogies can be used in nursing curriculum. In order to be successful, reflective practice must be interwoven throughout the curriculum. Much of the nurse’s clinical education is experimental learning. To be effective, the environment must be safe, rich, and provide opportunities for reflection (Benner, et al., 2010). Many times reflective practice is completed orally during clinical post-conference or simulation de-briefing. Wherein, the clinical instructor will ask the students to talk about their experience while offering questions for the group to reflect upon (Diekelmann, 2003). Another method is reflective journaling. Usually, students will require some guiding questions for their journals, but eventually reflective journaling becomes like second nature. Reflective journals are used to encourage the students to analyze an experience and determine the best approach to use in the future by examining the literature. Students can be transformed by these experiences, but only if they are able to notice and acknowledge the experiences (Benner et al., 2010). Nursing students must be engaged and play an active role in their learning.

These methods of reflective practice can also be used in the classroom. The nurse educator can facilitate Socratic discussions, where the students are encouraged to open themselves to new ideas and knowledge and to question the status quo. A case study or a lived experience that expands a student’s boundaries of knowledge can be reflected upon through group activities or narrative papers. Blogs and discussion boards can be used to have reflective conversations in the online classroom (Davis, Taylor, & Casida, 2011).
There are many other ways of using reflective practice in the classroom setting. The possibilities are endless. Reflective practice assignments can assist the nurse educator in knowing whether the student is truly comprehending content and making the appropriate connections between theory and practice. Reflective practice is not an ends to a means, it is a cyclic process that should continue throughout a nurse’s career. Reflective practice must be used in combination with other student-based and practice-based teaching strategies (Benner et al., 2010; Palmer et al., 1994). Reflective practice must be integrated into an entire program’s curriculum in order to obtain holistic results (McEntee et al., 2003). Nursing instructors must be well versed in reflective practice, in order to lead and guide students through the reflective process (Palmer et al., 1994). Reflective practice has immense potential in nursing academia.

**Conclusion**

Reflective pedagogies should be integrated into nursing curriculum. The literature, the experts, and this study elucidate the potential that the reflective practice phenomenon has for enhancing nursing education and practice. While technology and procedures may change, reflective practice is a skill nurses can use for their entire career. By guiding students through the process of reflection and providing them with a safe space for reflection, nurse educators can help them develop competence in reflection and enhance their learning for a lifetime. Nurse educators are in a position to provide nursing students with the tools needed for self-learning. There are numerous reflective practice techniques that can be used in nursing education and some can even be used as a means of assessment. Reflective pedagogies have the ability to transform nursing education and practice. Reflective practice can assist in the transformation of a student into a balanced nurse. Essentially, reflective practice supports the making of a butterfly – an expert nurse.

**References**


Author Note

Jessalyn Barbour, MSN, RN, OCN is an oncology clinical educator at Anne Arundel Medical Center in Annapolis, Maryland and an adjunct professor at Notre Dame of Maryland University’s School of Nursing.

This research was not supported financially by any grants or organization. Many thanks to Mary Packard, PhD, RN and Nadja Muchow, MS, RN, CBN for their support and assistance with this study.

Correspondence concerning this article should be addressed to Jessalyn Barbour, 4th Floor - Oncology, Anne Arundel Medical Center 2001 Medical Parkway, Annapolis, MD 21401. Electronic mail can be sent via Internet to: JessaBarbour@verizon.net
The Lived Experience of BSN Students in Caring Groups: Priceless

Carol B. Wilson, PhD, RN
Kathryn Grams, PhD, RN
University of West Georgia

Abstract

The commitment to caring is an essential component of a nursing program through the implementation of Caring Groups. The purpose is to create a context for experiencing and learning caring. An interpretive phenomenological approach was used to describe the experiences of students participating in Caring Groups. The findings support this strategy as an opportunity for students to learn caring through sharing personal experiences, growing in self-awareness and self-care, building relationships, and being part of a team. The findings will inform the further development of Caring Groups and guide other educational programs in implementing this strategy.

Keywords: caring, caring groups, teaching and learning

A University School of Nursing in a southeastern state embraced the call by the National League for Nursing (1988) for a curriculum revolution in nursing education with the renewal of a focus on caring. Faculty exploration of the work of nursing scholars related to caring in nursing education led to a curriculum revision that included caring as a central component of the philosophy (Diekelmann, 1990; Tanner, 1990). The commitment to “living caring” (Boykin, Schoenhofer, & Linden, 2010) by faculty and students has been implemented in the Bachelor of Science in Nursing program philosophically and experientially through the implementation of Caring Groups since 1992.

Background

The purpose of Caring Groups is to create a context for learning caring that can be translated into caring in nursing practice. Caring Groups are small groups of students that meet with a faculty member on a regular basis throughout the program of study with the intent of teaching/learning/practicing self-care and learning to care for colleagues. Previous research studies related to the Caring Group experience at this university from students’ perspectives supported Caring Groups as an effective strategy in nursing education for experiencing and learning caring (Grams, Kosowski, & Wilson, 1997; Hughes, Kosowski, Grams, & Wilson, 1998; Kosowski, Grams, Taylor, & Wilson, 2001; Kosowski, Grams, & Wilson, 1997; Wilson, C., Grams, & Kosowski, 1997). Results indicated that participation in caring groups enhanced the practice of self-care, increased cultural sensitivity and consciousness, and empowered graduates to recognize barriers to caring and challenge non-caring in professional practice settings.

Changes in the School of Nursing over time led to the need for a reconceptualization of the Caring Group experience for students. The initial format of one faculty member with one group of students during the entire program became impractical as the move from a small program awarding an Associate of Science in Nursing (ASN) degree to a large program awarding a pre-licensure Bachelor of Science in Nursing (BSN) degree on two separate campuses occurred. Because the faculty had a high degree of commitment to continuing the Caring Group experience for students, faculty brainstorming sessions were held and a decision was made that the clinical group in each clinical course would serve as the Caring Group for one semester with the clinical instructor as the Caring Group leader. Within this new framework, Caring Group members and leaders changed each semester, a complete shift from the previous format in which one leader facilitated one group for the entire program. Faculty expressed concerns about the effect of this new approach on being able to maintain the essence and integrity of the Caring Group experience. However, a plan for implementation was developed and the newly admitted 2008 BSN students were enrolled in the reconceptualized Caring Groups.

Purpose of the Study

As a result of the new of Caring Group structure, it was evident that previous research findings related to the meaning and significance of Caring Groups might no longer reflect the student experience, and a research study was designed to understand the continued value of Caring Groups as a tool for teaching/learning caring at this university. An interpretive phenomenological methodology was selected to explore the experience of participating in Caring Groups for graduates of the pre-licensure BSN program. Data from the study may provide direction for potential changes that may be needed in the new Caring Group model. Data may also inform other nursing programs wishing to utilize the Caring Group framework as an opportunity for students to experience and learn caring.

Literary Context

The literary context for this study is situated within the historical evolution of a focus on caring in nursing education programs that began in the late 1980s (National League for Nursing, 1988). As caring science evolved, nurse educators recognized that “if caring is an idea that
nursing practice and nursing education communities consistently use in describing the nature and function of nursing, then it would seem that caring would be a key area of study in nursing curricula" (Schoenhofer, 2001, p. 7). Caring has continued to be seen as a critical concept in nursing education (Brown, 2011; Drumm & Chase, 2010; Touhy & Boykin, 2008). The Carnegie Report on Nursing Education (Benner, Sutphen, Leonard, & Day, 2010) emphasized the need for teaching "nursing science and caring practices" (p. 24). Hills and Watson’s (2011) caring science curriculum model describes a process for achieving the integration of nursing science and caring practices as the center of nursing education. Previous research by the authors and their colleagues addressed the experiences of students participating in Caring Groups before the new framework was implemented. Findings from the initial phenomenological Caring Group study of ASN graduates indicated that the participants were able to create a caring community, experience the meaning and importance of caring in their professional and personal lives, learn to value caring and self-care, and become more accepting of others (Grams et al., 1997). One year after graduation, these same participants reported that they had experienced non-caring in practice but were able to transfer the caring learned in school and attempt to transform their practice settings (Wilson et al., 1997). Kosowski et al. (1997) studied the experiences of international students in Caring Groups. These students reported increased cultural sensitivity and consciousness, improved academic success, and personal and professional growth. A later study of the experiences of African-American students addressed issues of caring and diversity (Kosowski et al., 2001). A descriptive study by Hughes et al. (1998) found that students enrolled in Caring Groups described their peer interactions as more caring than those students enrolled in a traditional program without such groups.

Evidence of the continuing emphasis on caring in nursing education curricula can be seen in the work of other scholars in their use of educational strategies for teaching and learning caring. Brown’s (2011) model suggested “threading caring as a core value” (p. 363) in the curriculum through the use of affective learning objectives specific to caring that correlate with cognitive and psychomotor objectives. Birx, Wagstaff, and Van Patten (2008) described teaching caring through groups similar to those used at the site of this study. A caring curriculum in Taiwan that utilized a comparable format for developing their own caring groups has been reported in the literature (Lee-Hsieh, 2003; Lee-Hisheh, Kuo, & Tsai, 2004). In a second phase of the study, Lee-Hsieh, Kuo, Turton, Hus, and Chu (2007) reported that “the results showed that with appropriate curricula and learning strategies, caring skills may be learned” (p. 561). Caring teaching/learning strategies such as caring groups provide the opportunity for students to first “intentionally know the self as caring” (Pross, Boykin, Hilton, & Gabuat, 2010, p. 142). Pross et al. also stated that knowing self as caring is essential for engaging in caring relationships with others.

Research has also uncovered the meaning of faculty caring on student retention and success (McEnroe-Petitte, 2011). Creating caring relationships with students may be one way for nurse educators to identify at-risk students and provide assistance and intervention in order to promote academic success. Evidence of the influence of teaching/learning caring for students on caring and quality nursing practice is also found in the literature. According to Drumm and Chase (2010), new graduates who learned caring in their nursing program have the potential to create more caring work environments. The link between caring and quality patient outcomes is relatively new to the nursing science knowledge arena. Only recently has connection between caring in nursing practice and improved quality outcomes for patients been recognized. Duffy (2009), in her Quality-Caring Model®, theorizes that “relationship-centered caring” in nursing education and practice can improve patient safety and produce quality patient outcomes.

**Theoretical Context**

The theoretical context for the study is based on Boykin and Schoenhofer’s theory of Nursing as Caring (2001). They define caring as “an altruistic, active expression of love, and is the intentional and embodied recognition of value and connectedness” (Boykin et al., 2010, p. 372). Within this theory, “faculty assist students to come to know, appreciate, and celebrate both self and “other” as caring persons” (p. 377). The intention of the theory is to teach nursing as caring.

Caring Groups were initiated at the university school of nursing in order to create a context for students to experience and learn caring. According to Boykin et al. (2010), the process of learning caring “requires intention, formal study and reflection on personal experience” (p. 377). Activities within Caring Groups provide students with the opportunity to focus intentionally on caring for self and others as well as reflection on personal experiences of caring and non-caring. Through engagement in and reflection upon Caring Group activities, students have the opportunity to explore the concept of caring and the meaning of caring and self-care to successful nursing practice.

**Methodology**

A phenomenological approach was chosen for this research because it is an appropriate methodology to illuminate the lived world as it is subjectively experienced. According to Diekelmann (2001), a phenomenological approach guides the researcher in identifying patterns and themes and enhancing description of the common meanings and shared understandings embedded in the narratives of everyday experiences. Understanding the Caring Group experience of BSN students was the central aim of the inquiry and
focused on discovering individual perceptions of the phenomenon.

Participants
A purposive convenience sample was chosen from May and December 2010 pre-licensure BSN graduates at the university. These two groups of students were on different campuses but had the same curriculum taught by the same faculty members. Students were invited to participate in a study exploring their experience of participating in a Caring Group during their nursing education program. Institutional review board approval was received from the university prior to initiating the study.

The May 2010 graduating students were approached shortly before graduation. The purpose of the study was explained and students were asked to indicate their willingness to be contacted for participation after graduation by providing their e-mail and other contact information. After graduation, e-mails inviting participation in the study were sent to the graduates who had indicated interest. The response rate from these graduates who were already working and were no longer students at the university was not good. Follow-up phone calls were made in an effort to recruit participants. It was difficult to get volunteers to agree to come for an interview and only five graduates agreed to be interviewed. These interviews were scheduled and conducted in a room on campus away from the school of nursing.

Data from the December 2010 graduates were generated shortly before graduation, during a time when all of the students had finished class for the day. Students were provided information ahead of time about the study and were asked to volunteer to stay after class for an interview. Eight participants agreed to stay after class and met the primary researcher in a classroom at the university's off-campus site.

Of the 13 participants, 12 were female and 1 was male; 10 identified themselves as “white” or Caucasian, 1 was African-American, and 1 was Hispanic. The average age was 27, with a range of 23 to 43.

Data Generation
Data were generated from four audio-recorded interviews, conducted by the primary researcher. The participants agreed to be audi-taped and were interviewed regarding their experience in Caring Groups during their nursing education program. Each participant selected a pseudonym to be used in the study at the beginning of the interview process to protect confidentiality. Data were generated from two focus-group interviews conducted by the primary researcher with three participants in the first group and eight participants in the second; two individual interviews were also held. The focus group interviews lasted 45 to 60 minutes; the individual interviews approximately 30 minutes. The interviews began with a basic question, “Tell me about your experience during caring groups in the nursing program.” Additional questions were asked to enhance discussion, explore meanings, and seek information specific to the researchers’ areas of interest regarding this experience. These focused questions were related to the structural aspects of the groups, eliciting perceptions about changing Caring Group members and leaders each semester and suggestions about how to make the Caring Group experience better.

The interviews were transcribed verbatim by a graduate research assistant (GRA) in the school of nursing. The interview tapes were then edited by the primary researcher for errors and clarifications and to add nonverbal data from the reflective journal maintained by the primary researcher during the data collection phase of the study.

Data Analysis
Diekelsmann’s (2001) approach to interpretive phenomenology was used to analyze the interview transcripts. This method of data analysis guides researchers in reaching consensus about the shared story of the participants. Once the interviews were transcribed, the analysis process was initiated. The primary researcher, the other member of the research team, and the GRA read the interviews multiple times. For first level analysis, each research team member created summaries of the interviews, which were then shared with the other members of the team. Due to personal circumstances, the GRA withdrew from the research process at the end of the first level analysis. Second level analysis was conducted by the two remaining research team members and included ongoing dialogue about the meaning of the participant experiences and continued until consensus was reached regarding the essential elements of the data. Third level analysis continued until clear patterns and themes emerged, creating the possibility of a rich description of the stories of the participants. Methodological rigor was attained through adherence to the authenticity criteria outlined by Guba and Lincoln (1989) and included the peer debriefing activities identified above and member checking activities with the participants.

Findings
Caring Groups: “Priceless”
The findings from this study of student experiences in Caring Groups are best described in the following statement by Humbled: “Caring Group keeps everybody going….The Caring Group atmosphere “makes you realize you’re not on your own and there is always somebody you can get a hold of….Priceless, that’s how I would describe Caring Groups.” From the analysis of the stories of BSN students participating in Caring Groups as a component of their nursing education program, two major patterns emerged, Experiencing the Caring and Translating Caring into Practice. These stories focused on the importance of Caring Groups to the educational experience and the desire to translate what was learned into nursing practice.

Pattern: Experiencing the Caring
The opportunity to engage in teaching and learning activities related to caring is
The Lived Experience of BSN Students in Caring Groups: Priceless

described by the participants in the first pattern, Experiencing the Caring. The experience of caring was illuminated in three themes: Caring Group 101, Finding Common Ground, and Feeling Cared For. These themes provide a rich description of the experience of learning caring within the Caring Group model.

**Theme: Caring Group 101**

The basics of the caring group experience are described in this theme and include stories about the specific events and structure of the groups. Group activities included stress reduction, learning about self, and having fun. Eating, cooking, playing games, doing crafts, getting away from school, having secret buddies, going on field trips, and having a good facilitator were seen as important to the Caring Group experience. Toby stated that “my best times were when we stayed away from the nursing school and we were able to go out and just have a relaxing environment.” Susan described going to her instructor’s house, “hanging out, riding the boat around the lake…to take a break,” which was “really nice.” Enjoyment of arts and crafts was viewed as a positive Caring Group activity by the participants. Susan, Joey, Bobbie, and Lillian all described a craft activity during Caring Group that involved covering plates or boxes with pictures and words that described their classmates: Joey said that “it was awesome! I still have that box…on my nightstand” and Bobbie stated that she would “keep it forever and remember my Caring Group.” Overall, the participants reported that they liked the Caring Group structure that placed them in different groups with new group members and instructors each semester. As Bobbie described, “I’m so glad we did this [change groups each semester] because I would have never gotten to know that person. It makes you closer as a group.” Joey stated that meeting different students each semester in the group created a “kind of connection.” For Toby, changing groups and leaders “let you meet a lot more people and…get closer to the professors, not just one professor, but several of them.”

Additional reflections about the structure and function of the Caring Groups related to the scheduling of some of the group sessions and the attitudes and knowledge of particular faculty facilitators. Bobbie recalled the scheduling of one Caring Group meeting after a test. “We had to take a huge test and then we had to worry about going to that [Caring Group]….All I wanted to do was go home and sleep.” Casey stated that not all Caring Groups were structured in the same way and that she thought some groups were more cohesive than others. In relation to Caring Group leadership, Joey described a negative faculty leader experience as follows: “I dreaded Care Group. And to me it wasn’t the people I was around. It was just the…instructor who was involved…she didn’t seem to care either way. And she didn’t even know our names.” Susan reported that she had a Caring Group leader that “just really wasn’t sure what to do.” Fortunately, changing professors was generally seen as good and several students stated that they “didn’t have a ‘bad’ one [Caring Group leader] the whole two years.”

**Theme: Finding Common Ground**

In this theme, the stories of participants reflected the importance of the shared experience that involved getting to know other students and teachers, talk about feelings, relax, and find “common ground.” Learning that other Caring Group members were all going through the same thing was seen as a way of coping with the stress of school and learning how others were being successful in the program. As students engaged in activities intended to help them come to know self and others (team building activities, self-disclosure, sharing experiences), they were able to support each other. For Charlie, the group “just helps you know you’re not going through it alone.” Lillian identified Caring Groups as a “really good idea….You always had someone to talk to and you never really felt like you were alone.” Casey described common ground as: “It’s hard unless you’ve gone through it [nursing school]….They [family and friends] have no idea and they don’t understand.” It was especially important to her that when she “felt like an idiot” during the first semester of the program and didn’t know what she was doing, she learned that fellow students felt the same way. “Caring Group gives you support from the whole class.” Lillian echoed Casey’s view when she stated that “it was nice to be able to have a group to talk to….nobody else really understands.” Participants also reported that hearing instructor’s “horror” stories helped provide “insight” into their own experiences.

**Theme: Feeling Cared For**

The opportunity to experience support and connection among Caring Group members created an environment of feeling cared for and connected with Caring Group members. YaYa enjoyed having a “secret friend” because she also knew that “someone else was thinking of me.” Humbled described feelings of support as he indicated that he “never would have been successful in the program if there had not been Caring Groups.” For YaYa, the experience of Caring Groups was seen as getting “personal with all your classmates and colleagues and you know you can go to them.” Eva’s story of feeling cared for comes from a clinical experience in which she recalled crying in front of her classmates and professor at the end of a clinical day. “It was such a wonderful feeling when I left there to know they were supportive of me.” The caring relationship was so strong in one group that Emily continued to receive weekly “gifts” from a classmate who had dropped out of the program. “It made me feel so good that she continued to care even though she wasn’t a part of our group anymore.”

**Pattern: Translating Caring into Practice**

The second pattern, Translating Caring into Practice, emerged from the data related to participants’ desire to create a caring environment in their practice settings after
graduation. The stories in this pattern focus on two important aspects of caring, identification of the need for self-care and the desire for teamwork. The first theme, Self-Care: “You have to take time out,” includes stories related to the understanding of the need for self-care in order to manage the stress of nursing practice. The second theme, Teamwork: “nurses that have got your back,” describes the desire to work in an environment that is caring and teamwork-centered.

**Theme: Self-Care: “You have to take time out”**

One common story from the Caring Group experience, for these participants, was acknowledging the need for self-care in their future nursing practice. There was general agreement that self-care was important and something they had to figure out how to find the time to do. Lillian felt that “I’ve learned to be really assertive….I learned… that I have to take time for myself, otherwise I’m going to get stressed and overwhelmed and start acting crazy….so I’ve definitely learned to take care of myself.”

Susan also indicated that Caring Group “helps you to understand that you have to take time out.” YaYa described how she learned caring for self from Caring Group: “Most of our instructors emphasized caring for ourselves….It was important to hear that you can take time to care for yourself.”

Mary described the importance of “the time we take to care for ourselves and care for others.” For Susan, learning to care for herself involved becoming more assertive and speaking up when work expectations are inappropriate.

**Theme: Teamwork and support: “Nurses that have got your back”**

For the participants in this study, the Caring Group experience created a desire for a nursing practice setting in which there would be collegial caring and a sense of team. As Charlie stated:

“I’m not really in a position to turn down a job right now, but I so would not want to be on the night shift here [where she currently works] because I just feel that they don’t work well together and there is nothing like teamwork. That [no caring among colleagues] makes a huge difference. I’d take less money for a better team.

Eva’s story mirrored Charlie’s when she stated that “what I look for in a job is a place where there is teamwork…collaboration amongst the other nurses…nurses that have got your back….I don’t know that I’ll be satisfied with any other type of situation.”

Casey indicated that she would “definitely try to seek employment where there’s a lot of teamwork and support.” For Joey, it seemed possible to recreate a caring environment in practice. “If you’re willing and you’re open about it, it recreates itself [caring work environment].” According to Humble, “Caring Group facilitates the working with a team concept….You learn to get along with different types of people.” He recognized that “if you try to do it all on your own, you’re going to put yourself in a lot of trouble.”

Mary concurred with Humble’s view of the need to learn teamwork. “We are part of a team….we have to learn how to deal with each other’s points of view even if they do not agree with us.”

**Discussion**

This research utilized an interpretive phenomenological methodology to describe and analyze the experiences of 13 students participating in Caring Groups, an experiential teaching-learning strategy related to caring. The participants in the study were enrolled in a BSN program in a university school of nursing and were the first cohort of students to experience a new Caring Group framework. The first pattern of *Experiencing the Caring* illuminated stories within the themes of *Caring Group 101, Finding Common Ground and Feeling Cared For*. The second pattern, *Translating Caring into Practice*, explored participant experiences of *Self-Care and Teamwork* in their practice settings. Caring Groups as an intentional teaching-learning strategy is supported by the work of Boykin and Schoenhofer (Boykin et al., 2010) as a way to prepare graduates to “live caring” for themselves, their patients, and their colleagues in nursing practice. The evidence is clear that participation in Caring Groups provides an opportunity for students to experience and learn caring through sharing personal experiences, growing in self-awareness and self-care, building relationships, and being part of a team.

Findings from this study related to the structure of Caring Groups and the role of the faculty facilitator are consistent with previous research by the authors and their colleagues in which students reported that activities such as eating, participating in stress-reduction exercises, playing games and doing crafts were important in creating a context for caring (Grams et al., 1997; Kosowski et al., 1997; Kosowski et al., 2001). Just as participants in this study reported, previous students identified the role of faculty as critical in shaping the group experience. While most of the stories about caring group leaders are positive, previous and current research include “negative cases”. The few negative comments about the Caring Group facilitators in the most recent stories resonates with the findings of the study by Kosowski, Wilson, and Grams (2004), which reported that faculty experienced a “burden of caring” (p. 32) and expressed concerns about the challenges of being a good leader.

The experiences within the themes of *finding common ground and feeling cared for* are essential components of the “bonding and connection” that was reflected in the experiences of previous Caring Group research participants. The earlier Caring Groups were a place where students could share their personal lives, empathize with the needs of their classmates, and learn about “being there for each other” (Grams et al., 1997, p. 14). Previous students also found the support they needed to be successful in a rigorous academic program like nursing, just as Humble did in this
The Lived Experience of BSN Students in Caring Groups: Priceless

study. The practice of encouraging reflection on self and self-care in the groups seems to be essential and is explored in current scholarly work related to the importance of “coming to know self as caring person” (Boykin, et al, 2010, p. 377). Feeling connected was fundamental to the experiences of international students who shared their cultures (Kosowski et al., 1997) and African-American students who were able to lessen barriers of race and ethnicity (Kosowski et al., 2001) in their groups. The universal story that only those going through the same experience together can truly understand the nature of the experience was present in all participant stories. It provided an opportunity to “know oneself” through “knowing another” in caring.

Participant reflections on what seemed important in learning caring gave voice to the desire to translate caring practices learned in nursing education into caring behaviors in practice, which supports earlier research related to the Caring Group experience. Caring Group members from previous studies not only identified a desire to recreate the caring community experienced in school (Grams et al., 1997) but became empowered to transform non-caring work environments (Wilson et al., 1997). For these and previous graduates, working in a caring practice setting was empowering, enabled self-care, and promoted teamwork. The work of Drumm and Chase (2010) supports the finding that a caring educational environment can evoke caring in practice. “Through the learning of caring, new graduates can transform practice settings to caring environments instead of environments that are procedural, automatic and insensitive” (p. 36).

Implications
Findings from this study will inform the further development of Caring Groups and guide this university and other educational programs which may wish to implement this strategy as a way to teach and learn caring. The changing of group members and faculty leaders each semester was viewed as beneficial by the participants. Participants reported that sharing personal experiences with a greater variety of faculty members increased their own insights about nursing practice. Lillian liked having different instructors and group members and believed that it helped her know more of the class as a whole. As Nina stated, “it makes you closer as a group. It really does.” Participant stories emphasized the need to prepare faculty for the role of Caring Group leader. An ongoing program that involves the mentoring of new faculty by experienced and effective Caring Group faculty is essential to the continued success of this teaching-learning strategy. Additionally, factors related to the scheduling of activities need to be explored.

Recommendations for Further Study
Further research is needed to create connections between caring theory and research and nursing education and practice. The link between caring and quality patient outcomes is relatively new to the nursing science knowledge arena. It has only been recently that the connection between caring in nursing practice and improved quality outcomes for patients has been recognized. Duffy’s (2009) model, quality caring in nursing, could be used for further research to determine the link between caring in nursing education, caring in nursing practice, and quality patient outcomes.

Although “negative cases” are a small component of the stories of the participants, strategies are needed to ensure that all students have a good experience. Further research is needed to understand what creates the context for a “good” versus “bad” Caring Group experience. One way to achieve this might be through research to learn more about ways to support Caring Group leaders in their role. While the stories of participants in this study provide evidence for Caring Groups as a way for students to find support during their nursing education experience, further research is needed on the impact of faculty caring on student retention and success (McEnroe-Petitte, 2011).

Research on Caring Groups at this university has focused entirely on undergraduate students, primarily associate degree students but also baccalaureate students with this study. Even though these programs have incorporated some online technology to support learning activities, courses have been delivered face-to-face in on-ground classrooms and traditional clinical settings. The university school of nursing is in the process of expanding Caring Groups to the RN-BSN program and graduate level students via online technology in hybrid and 100% online courses, which offers other opportunities for future study.

The body of knowledge in caring science is growing, and the role of caring educational practices in creating caring environments for patients and nurses is increasingly evident. Caring Groups and similar teaching-learning strategies have the potential to enhance student experiences and transform practice.

References


The Lived Experience of BSN Students in Caring Groups: Priceless


---

**Author Note**

Carol B. Wilson, PhD, RN, Professor, and Kathryn Grams, PhD, RN, Dean and Professor, School of Nursing, University of West Georgia, Carrollton, Georgia.

Correspondence concerning this article should be addressed to Dr. Carol B. Wilson, School of Nursing, University of West Georgia, 1601 Maple Street, Carrollton, GA 30118 USA. Electronic mail may be sent via Internet to kgrams@westga.edu
Becoming Whole: Kari Martinsen’s Philosophy of Care – Selected Concepts and Impact on Clinical Nursing

Charlotte Delmar, PhD, MSN, RN
Aarhus University

Abstract

There seems to be a schism between philosophical descriptions of care ethics and nurses’ concrete experiences with nurse-patient collaboration. The article uses the Norwegian doctor of philosophy Kari Martinsen’s phenomenological philosophy of care as a framework to reflect on and connect to the impact on nursing. Nursing as a relationship-based moral practice is understood in the light of the philosophy of connected relations, the source of morality, and the concrete practical situation. Love, trust and power reflect the ethical demand in the concrete and asymmetrical nurse-patient relationship. Becoming whole; nursing practice and a philosophy of care are to be understood as intertwined.

Keywords: Caring, nurse-patient relations, nursing practice, holism, nursing philosophy, care ethics

Introduction

The aims of this article is to present and interpret the phenomenological philosophy of care of Norwegian nurse and doctor of philosophy, Kari Martinsen, as it was subsequently linked to concrete nursing practice. The article is motivated by a schism between philosophical and theoretical descriptions of the concepts of caring and care ethics and different experiences from clinical nurses and empirical research.

The concept of nursing is understood as a relationship-based moral practice, and relations, moral, and practical care are to be understood as a whole in the concrete nursing practice. Nursing as a moral practice is closely connected with a basic understanding that caring for others and the values rooted in care ethics are grounded in a relational view of human beings. Moral practice is about a relationship between people bound by charity and practical abilities. In nursing, care is a prerequisite for exercising good nursing, thus care and nursing become a unity.

Taking this starting point in the philosophical and theoretical approach to care and care competences, I have been convinced by clinical nurses about the challenge of going to the root of the matter – the concept of care ethics. Nurses experience an incompatibility between normative good care, especially considering in Kari Martinsen’s philosophy of care, and actual nursing performed. Nurses would like to act upon the patient’s appeal for help because such a receptive attitude might help to increase the patient’s space for action. Apparently, everyday routines prevent nurses from living up to the ideal of good care. Therefore, by linking philosophy to nursing practice, the intention is to show that many different factors reflect the ethical demand in the concrete and asymmetrical nurse-patient relationship.

From Marx to Logstrup

Kari Martinsen has for the past 34 years advocated that care is and should be a prerequisite for good nursing. Care is the basis of all human relations; the same applies to care in a nursing context. But in nursing, care is expressed differently and linked to carrying out practical tasks in an asymmetrical nurse-patient relationship; in nursing, care is not a mutual give and take relationship similar to friendships and family relations.

It would be difficult to point to one main work by Martinsen on the philosophy of care, as her writing and understanding involve a continuous, moral, philosophical development of care in nursing. Fra Marx til Logstrup (From Marx to Logstrup) (Martinsen, 1993) introduced and was a focused unfolding of writings of the Danish philosopher K.E. Logstrup, a faithful companion to Martinsen and her understanding of nursing. The most recent publication is Logstrup og sygeplejen (Logstrup and nursing) (Martinsen, 2012). The origin of the philosophy of care is from Fra Marx til Logstrup (Martinsen, 1993), describing the foundation of relationship-based moral practice, which is the focus of this article.

However, the choice falls on the work Fra Marx to Logstrup (Martinsen, 1993), the previous larger work from 1989 is the collection of articles, Omsorg – sykepleie og medicin (Care – nursing and medicine) (Martinsen, 1989), including articles written from 1979 to 1988. During that period, Martinsen conceptualizes care and is inspired by the German philosopher, Martin Heidegger’s (1886-1976), central concept of caring. Martinsen begins to seek answers to her own fundamental question on what care is and what it includes (1989, p. 68). In the article from 1981 Omsorg i sykepleie (Care in nursing) (1989, pp. 67-82), Heidegger’s theoretical analysis of human being’s practical life is the foundation for Martinsen’s work on care as a practical and connected concept. In the article from 1988, En moralfilosofisk og social-politisk forståelse af omsorgsbegrebet (A moral-philosophical and social-political understanding of the concept of care), the morality of care is clarified (1989, pp. 42-66).
This collection of articles is an inspiration and many parallels can be drawn to Martinsen’s current phenomenological thoughts on care. Though it is difficult to bring out the main features of the philosophy of care, I will let the collection of articles rest for the following reasons: First of all Martinsen has, for credibility reasons, renounced her work on Heidegger. In the 1990s, it was well documented that Heidegger’s German national socialistic commitment was reflected in his philosophy (Martinsen, 1995, pp. 16-17). Secondly, in these previous articles Martinsen conceptualizes care. With Martinsen’s moral philosophical development, which brought her to the Danish K. E. Løgstrup (1905-1981), care must be understood and shown in practice. Care is not a conceptualization because care becomes alive and present only when it is unfolded.

The Structure of the Article

It is a difficult matter to bring out main features of Martinsen’s philosophy of care, because her philosophy is not a logical construction of concept and theory, but instead a phenomenological unfolding of care and ethics. But it is not my job to plagiarize, but to present and interpret selected meanings of Martinsen’s thoughts, followed by a connection to understanding practical nursing with the purpose of showing how different concrete factors reflect the philosophical approach.

In each of the sections concerning the essential meaning of relationship, morality, and practical care, I first present Martinsen’s philosophical understanding of care common to all human beings. In order to show care in universal relationships as well as in nursing, I discuss when care appears as a universal phenomenon and when the phenomenon relates to philosophical nursing. I then amplify and supplement the discussion with a practical nursing understanding of the Kari Martinsen’s philosophy of care. In the following section, morality and ethics are used synonymously.

The Relations – Grounded in Interdependence

Care is the basis of all human relationships. Therefore this section is first and foremost a universal interpretation, followed by a section tied to the impact on concrete nursing practice.

First, in the words of Løgstrup, interdependence or the fact that we fundamentally are dependent on each other, means that we cannot meet each other without being in a mutual relationship, where we mutually hand ourselves to each other. It might sound like a claim, but in Den etiske fordring (Løgstrup, (1956)/1997) (The Ethical Demand, Løgstrup, 1997), Løgstrup especially in the first chapter has presented a phenomenological analysis of the origin of the ethical demand, which is precisely that a person has his/her reality with other people and that we give each other reality. Thus, the individual person belongs in a world, where he/she has something of the other person’s life in his/her power. To Løgstrup, this is so basically and fundamentally human that metaphysical interpretations should not necessarily be brought together with this conception (Pahuus, 1991). But as I started off with Martinsen’s philosophy of care, I should here connect to the idea of the Creation, because Martinsen refers to that which is given unto us.

Martinsen justifies Løgstrup’s idea of Creation, which expresses itself in different ways in all of his work. Løgstrup deliberates about the idea that Creation can be understood in a phenomenological way. It can in a certain sense be substantiated empirically. But in other works, the idea of Creation is also linked to a common religious and Christian perspective (Martinsen, 1993; Pahuus, 1991). It is important that Martinsen leads a discussion about Creation as a theological or philosophical interpretation and concludes that Løgstrup’s idea of Creation is a philosophical human-based idea (Martinsen, 1993, p. 67). Martinsen does not stand alone with such an assertion. Other Løgstrup interpreters also reach the conclusion that the fundamental understanding of life is based on this Grundtvigian1 inspired, human access (Hauge, 1992, p. 151, 600; Thomassen, 1992, pp. 15-17, 200).

That people depend on each other is to Martinsen rooted in this basic assumption. The living experiences show that two conditions play a role here. Partly that something is given unto us and partly that we receive the given, we are in a receiving relationship (Martinsen, 1993, pp. 54-55). It can also be expressed as what is given unto us is life, is in itself structured and contextually and wisely decided. It is decided in the meaning of receiving one another. It can also be expressed as the character of the gift of life, like life is given as a gift and the gift is to be received. A gift is received immediately and openly without ulterior motives, without calculation, and with joy. It is the joy or the gratitude which is the reception. To receive the other as a gift demands that you enter the relationship, an “ethic of gift” as Martinsen calls it (1993, pp. 58-59, pp. 78-80). It also demands that we give without reservation in the same way as we receive. A negative act of giving is selfishness and the conquering of the other. If subjectivity and a productive man who is endlessly in need of fulfilment advances dominate, then the idea of the Creation with its receiving the other is a critical counterpart or a criticism of culture (Martinsen, 1993, pp. 11, 56, 61, 63-65). In the understanding of life of the idea of Creation, everyone has the same dignity because we are created. You cannot put a price on a human being. Responsibility for the weak is the most fundamental ethical principle; you cannot question human worth. Interdependence or the fact that we fundamentally depend on each other is by Martinsen expressed by the understanding of life through the idea of Creation. This implies that life is given unto us and that in life a person has his/her reality together with others. We are intertwined and in this intertwining we are handed over to each other.

1 N.F.S Grundtvig (1783 – 1872). A Danish priest and poet, famous for his promotion of a special kind of School in Denmark (Folkehøjskole) with its values on community, dialogue and mutual relationships.
Becoming Whole: Kari Martinsen’s Philosophy of Care – Selected Concepts and Impact on Clinical Nursing

Interpretation of the Philosophy and the Impact on Nursing

The idea of Creation, meaning that life is given unto us in dependence on each other, is so fundamental that we do not even think about it. The fundamental is caught in us. It is more than we can know. The nursing profession deals with human questions; the important questions concern how the nurse and the patient relate to each other. With this focus, Martinsen’s fundamental view on dependence will be reflected and the symbolism of the act of the gift and her view on human worth.

Dependence with a Relational Perception

The fact that people depend on each other is problematic, because people strive for independence and self-management (Delmar et al., 2011). Technical rationality dominates and is society’s prevailing value. To a great extent these values also exist within the Scandinavian healthcare system and nursing. Therefore appreciating care and stressing that people depend on each other can also be considered an attempt to undermine existing society.

Dependence is a negative word in western societies. But it is only from an individual perception that dependence and self-management are opposites. The central part of such perception is that the individual person is self-reliant and will strive to be self-managed.

There is nothing wrong with striving to be self-managed, but if the management of a patient’s independence, self-management, and self-care is the result of absence of nursing care, it easily becomes the patient’s own problem to solve different tasks related to his/her condition. If the purpose of nursing is defined as self-management, the danger lurks in unjustified rejection of the patient’s plea for help, e.g., rejecting help to get dressed or to perform daily hygiene. From the conception that fundamentally a person wants to strive to be self-managed, it could easily become an individual perception that everyone has to be self-managed. It is important to think that what could seem unbearable without the help of others, can with the care of others become bearable (Delmar et al., 2006).

In Martinsen’s philosophy of care, dependence is a positive word. With a relational perception, there is no difference between dependence and self-management. It means that it is in mutual influence, that a person can develop independence and the space to act. The patient’s self-development and space to act can be extended or narrowed in mutual affection. Just think how affected one’s own mind or self-unfolding becomes when surrounded by happy, irritated, or angry people.

The Act of Giving

Reflecting on the symbolism of the act of giving shows that the character of the act of giving forms the basis for how the patient is encountered. But Martinsen’s view, using the symbolism of the act of giving in our time, is not entirely without problems. Receiving with joy can be a difficult matter, especially for many women. Documentary descriptions of women who have become ill have shown their difficulty in receiving. Women, through their upbringing and taking on the role of housewives, among other things, have given love all their lives.

There are other notions about giving gifts. In social anthropology, the exchange of gifts is an exchange. The function of symbol is a social fact which is practiced as a given (Merleau-Ponty, 1969, pp. 181-182). It is a norm in society that you give a gift expecting to get one in return. What purpose does the gift serve in this context? It is giving a gift an exchange and a matter of expecting as much next time? In Martinsen’s philosophy of care, the act of giving is an altruistic reciprocity where the charity is given as a gift without expecting something in return. It almost sounds like a calling where the self-sacrificing act is caught in the nurse. In one way, you can see the self-sacrificing nurse as one who endlessly tries to please the needs of all patients as well as meeting reasonable and unreasonable requests and expectations. It is the nurse who takes on the role of a counsellor everywhere. On the other hand, an altruistic mutuality is marked by the nurse being aware of his/her role in an asymmetrical mutual relationship (Berthelsen et al., 1992; with Kari Martinsen, Personal communication, pp. 57-66). The nurse in the asymmetrical relationship must be able to move between proximity and distance or between confidentiality and alienation.

Interpretation of the Philosophy and the Impact on Nursing

If, for example, the nurse reveals his/her entire emotional life to a patient who in the situation becomes a close friend, the relationship is not characterized by an altruistic mutuality; the nurse practicing care is not aware of her professional role and the relationship is based on private mutuality. In a professional nurse-patient relationship, the nurse does not expect to get anything in return. However, he/she does get something in return. The patient’s trust can become the personal driving force and by some perceived as a calling, but in a more modern version, a humane act.

The interaction between nurse and patient is an asymmetrical, dependence relationship and a collaboration in the name of charity. Collaboration, or working together, can be both good and bad. The collaboration in the name of charity is that one cannot question the human worth. As people, we have equal worth, meaning equally valuable, even though some have a job and others do not. Even though some have been categorized and perhaps stigmatized as drug addicts and others as alcoholics. It is in this context that the nurse may challenge a society which puts a price on human beings (Martinsen, 1993, pp. 63-65). A nurse is close to the patient as a human being on an inter-human level and respects human worth along with the possibilities and limitations involved in the relationship.
Love and Trust as Sources of the Moral Care

Love and trust in a situation are important sources of moral care. Martinsen’s philosophy of moral nursing care follows from the perspectives of the universal human being’s understanding of love and trust.

Love and Trust as Universal Phenomena

Logstrup and Martinsen are representatives of ontological situation-ethics or ethics based on human beings intertwined with each other, but at the same time attaching great importance to the duplicity of the situation: A situation is typical because in relationship there will always be some typical features which are recognizable from previous situations. At the same time, a situation is unique because of the irreversibility of time. The same situation will never happen again. The basis of moral care is neither principles nor consequences, motives or duties, which teleological and deontological traditions prescribe. But neither is it the uniqueness of the situation where the unique is so prominent that nothing can be transferred to or from other situations; because with this existential situation-ethics the basis is an individual perception.

In the intertwining situations, we are reaching out to each other. The other makes an impression on me and I am moved sensuously, bodily, and in impression; there is an appeal to take care of the other’s life and to act for the good of the other (Martinsen, 1993, pp. 19, 57). “We are bound to each other with a demand to take care of the other’s life, and we are at the mercy of the union” (Martinsen, 1993, p. 71).

There is an ethical demand or appeal which Løgstrup, according to Martinsen, also called love (Martinsen, 1993, p. 72). To Løgstrup and Martinsen, love and care are all-present phenomena which are universal and unfounded. Being universal means that something is not attached to gender. The appeal of love is silent, unspoken, quiet and invisible, and hidden in the situation. Love has two sides. Love is spontaneous and universal; the modesty of the ethical demand or love is an idea, it is an ethical demand. That love is spontaneous and universal means that love shows itself as an altruistic act, which takes us by surprise, before we know it (Martinsen, 1993, pp. 74-78). In the spontaneity a universal feeling is expressed, a possibility of life directed at the other, for the other’s sake, beyond oneself. It is a bound feeling, because it is bound to something beyond oneself. Thereby love reaches beyond itself and opens a field.

The feelings are admission granting and are attached to the reality from which they come. The admission granting feelings recognize the basic conditions of life as connected. When feeling loses its restraint, it becomes sentimental care. It does not give any recognition. That love is an idea means that when love is in hardship, arguments, rules, and principles can step in, in order to preserve love. Love as an idea is a normative morality created by society, which can step in, if there is conflict between selfishness and the other or if the situation is complicated (Martinsen, 1993, p. 77).

Love as spontaneous and universal is a manifestation of life. As Martinsen points out, Løgstrup’s further work on the supreme manifestations of life is a development of spontaneous and universal love. “The manifestations of life are even the spontaneity of love, the modesty of the ethical demand” (Martinsen, 1993, p. 83).

Here the demand is superfluous in the situation; it is silent and unspoken. The manifestations of life are spontaneous; they catch us by surprise before we know it, and we are caught by them. The manifestations of life are spontaneous; they are not our own achievements; the manifestations of life such as trust, mercy, compassion, hope, and the openness of speech are good, before we make them good. In other words: without them, a person cannot exist. They carry our lives. They are fundamental to our lives with each other, and through the manifestations of life we are handed to each other in order to act according for the good of the other. Opposite demands cannot be made based on the appeal of the situation. It is an ethical demand to take care of life, which trust and other manifestations of life put in our hands.

In Den etiske fordring (Logstrup, 1956/1986) (The Ethical Demand (Logstrup, 1997), Logstrup has chosen a phenomenological analysis of trust, and it is highly central in relation to Martinsen’s section on the forms of expression of connected relationships (Martinsen, 1993, p. 58): “By our very attitude to one another we help to shape one another’s world. By our attitude to the other person we help to determine the scope and hue of his or her world, we make it large or small, bright or drab, rich or dull, threatening or secure. We help to shape his or her world not by theories and views but by our very attitude toward him or her. Herein lies the unarticulated and one might say anonymous demand that we take care of the life, which trust has placed in our hands” (Løgstrup, 1956/1986, p. 28; Løgstrup, 1997, p. 18).

Trust cannot be created. It is always present in our lives. But we can destroy trust, so that mistrust appears (Martinsen, 1993, pp. 60-61). Mutuality is vulnerable. Because in our mutual dependence on each other we are included by power, when a person trustingly exposes himself/herself. A receptive attitude can increase the other’s space of action by making the other’s worldwide, light, multitudinous, and secure. A rejecting attitude involves thinking of conquering supremacy, and it can destroy the other by making the other’s world narrow, dark, boring, and threatening (Martinsen, 1993, p. 11). A morally responsible execution of power acts in such a way that the other’s space of action is increased. The ethic is spontaneous in its reception; the act is spontaneous.

The possibility of rejection is always present. To be bound more by rules and principles than by people is one example of how the balance of power can be morally irresponsible. Attention is derived from the other, and the rules and principles are used.
in order to obtain supremacy (Martinsen, 1993, pp. 73-74). However, that does not mean that rules and principles are not necessary. They only come second in a morally responsible execution of power. Therefore the manifestations of life cannot always be obeyed. If there is a conflict between the selfishness and the other or if the situation is complicated, then love as an idea has to step in (Martinsen, 1993, pp. 60-61, pp. 84-87).

The two sides of love exist in real life. Love appears as an appeal, as spontaneous and universal. The appeal is always present but hidden. In difficult situations, demands are made to act in a good way and the formulation of love as an idea steps forward as a demand (Martinsen, 1993, pp. 88-89).

**Love and Trust in Nursing Philosophy**

Love in nursing: What about that according to Martinsen? What understanding of love or care can contain the phenomena of human life such as loss, suffering, and pain? Such phenomena are common in the ill person.

If the nurse is to see the appeal which lies in the patient’s situation, he/she must be aware that love in nursing is a prerequisite. Thus, nursing becomes a work of mercy where the ideal of a relationship-based moral practice is to be taught and followed. Like a power of example, it is a demand to learn and live according to the good nursing attitudes and – actions, where the demand points towards the possibilities, which have already been given with life. To live by the ideal of mercy will open up to the manifestations of life, so the mercy can take over the nurse (Martinsen, 1993, pp. 62-63, 93).

In order to live by the ideal, the nurse must meet the patient in a relationship of charity, a sincere, open, and receptive relationship, where the supreme manifestations of life are put into play along with a professional assessment or professional judgment. Professional assessment is the estimation or the reflection and founded in spontaneous love, the spontaneous and supreme manifestations of life (Martinsen, 1993, pp. 89, 97). The spontaneous manifestations of life and reflection are united opposites, meaning they determine each other, and reach into each other. One cannot be without its opposite in the other (Martinsen, 1993, pp. 37, 75).

In practical nursing, spontaneous love and mercy have no impulse. This eases our interaction with each other and saves us from emotional and sentimental care. But it can also be used as a creator of distance, meaning that norms and principles in professional assessment rise and lose their foothold in the concrete: “For it is the confrontation with the concrete, with the situation, which makes the common norm ethical” (Martinsen, 1993, p. 91).

In order to establish a professional relationship, Martinsen believes that the nurse who is altruistic and interested in the patient builds on practical knowledge and can open up to the possibilities of love (Martinsen, 1993, pp. 90-91, 102). Then the nurse can help the patient with phenomena such as loss, suffering, and pain, if the personality is there as a “collected strength” (Martinsen, 1993, p. 152). Even though trust and the other manifestations of life are always present, the relationship is vulnerable and the possibility of rejection always present. For example, the patient’s reactions to suffering in the shape of aggressiveness or giving up can demand the nurse’s full effort and openness in order to understand why this particular patient reacts in this way. In other words, the importance which the nurse puts on the phenomena in the connected relationship is vital to bring out meaning in the practical nursing actions bound by the situation; this is only possible if the nurse is in a sincerely receptive relationship.

**Interpretation of the Philosophy and Impact on Nursing**

The manifestations of life such as love and trust are bearers of our lives. The manifestations of life are so fundamental that without them a person and the world would perish. Just think about what the violence of the world could lead to without hope, love, and the compassion and mercy for others. A world influenced by mistrust would not be able to exist.

But what does it mean to live out the manifestations of life in nursing as moral practice, when the nurse in the asymmetrical relationship must live in the unifying contrast between proximity and distance? In practical nursing, it is no secret that it is hard to live by, because many different factors play a role and make acting in relation to the manifestations of life difficult. In concrete situations, trust is vulnerable and power can easily get the upper hand and be used in a morally irresponsible way. Power will narrow the patient’s space of action.

**Trust and Power**

In the following section, I will try to clarify the importance of trust as something fundamental in nursing as moral practice and briefly mention the wrong ways of care, which in nurses become simplified perceptions and therefore cannot earn the right to be termed care.

Trust is a surrender of oneself; because in it lies an expectation that the other receives the shown trust and thereby does something. In it lies an ethical demand that power in the relationship is handled so that the patient’s space of action increases because in inter-human relationships we are always included by power. Power is connected to our life unfolding and is not always evil (Logstrup, 1972/1976, pp. 115-117). The difficult question is how power is exerted.

The nurse has authority in his/her position and uniform (which some consider a work outfit, perhaps to diminish the authority), pins, professional knowledge, and personal charisma. If the nurse uses this authority in an authoritarian way, then it is abuse of power and not a morally responsible exertion of power. But how to act in a way that benefits others the most?
When is it exertion of power? When does the nurse let the unifying opposite of proximity and distance stand on their own? And how do the nurse’s feelings and personality play a role?

You can call it clinging care when proximity is on its own. If the nurse’s feelings become private and self-centered, for example, in a dialogue focusing on the fear of death. If the nurse is not able to placate the patient’s fear because of his/her own fear of death, or if the nurse gets carried away with feelings in misunderstood pity for the patient, there is a risk that nursing freezes in emotionalism and sentimental care. The feelings become encircling and enclosing and therefore give no recognition. The situation disappears.

If the nurse distances himself/herself and objectifies the patient through superior knowledge, or if he/she is more bound by principles, rules, and standards than by the concrete situation, then the situation disappears. It diverts attention, where the nurse is more preoccupied by her own excellence and the patient is stripped of the possibility of participating in his/her own care. The care freezes, in the words of Martinsen, in supremacy thinking and objectifies the patient through superior guardianship when the nurse protects the weak one. You can also call it negative guardianship when the nurse protects himself/herself from personal own vulnerability to such a degree that the protective distance loses the concrete situation.

Clinging care and negative guardianship become self-centered and passive. Passivity means that the attention directed at the patient disappears and the patient’s space of action is narrowed or destroyed.

**Trust is Given**

So what does it mean that trust is given to us? I have often discussed with students and nurses the immediate existential claim that trust is given. They often say, “It cannot be that trust is always present.” And often I hear that we must create trust between nurse and patient in order to make the patient feel safe. But trust cannot be created; it is given unto us. On the other hand, it is about correcting conditions so that trust can develop. It takes infinitely small but special circumstances to destroy trust. When the patient is refused, power has not been managed in a morally responsible way and the trust is broken.

Trust belongs in every conversation. But what about the patient who shows up with mistrust? These patients may have had unfortunate and repeated experiences in the health service system. They express mistrust in the system and do not mistrust the nurse who meets the patient for the first time. The nurse must first violate the patient’s trust, when he/she has trusted the nurse. If the nurse does not hear the patient or ignores the tone of the conversation, he/she demonstrates a rejecting attitude. The nurse has not been receptive. Power has been used in a way where the patient’s world becomes more vulnerable. The reciprocal relationship is vulnerable.

That does not mean that a nurse’s firm and decisive tone implies rejection of the patient. On the contrary, in some situations it is necessary to show authority. By using a calm but firm tone, for example, a severely affected patient suffering from pain caused by a heart attack might feel that he is in safe hands.

Avoiding answers or making ambiguous statements in a conversation, possibly combined with a shifty look either due to the nurse’s own insecurity or because of work pressure, can break the best relationship. Many nurses recognize situations where at least part of a conversation or the lack of it has happened with one foot in the corridor. Withholding important information vital from the patient by being silent is another example.

Silence is seen here as destructive of trust between the nurse and the patient. Another example is when one of society’s law-breakers is admitted to be nursed and treated. In most cases, it is up to the nurse to be silent to the system and protect confidential information. Silence builds trust between the nurse and the patient.

However, these are not only ethical decisions but also legal questions, which is why I will not discuss this problem further.

Physical touching has been seen as a positive act in nursing, not in the least because in this situation a message can be communicated to the patient. Physical touch demands an awareness of the power of the body in the relationship, because if the patient feels uncomfortable by the expertise and practical skills of the nurse, basic trust can be destroyed. In such situations, the patient can see an indulgent pat on the shoulder, an indulgent smile, or a distanced look as an expression of the nurse’s indifference to him/her as a fellow human.

Other issues demanding the nurse’s efficiency and moral attitude include a situation well known to nurses, where the recent postoperative patient refuses to get out of bed the day after the surgery. How is the nurse to act with a receptive attitude? The actual, concrete circumstances decide this, but he/she has on one hand to weigh how far the patient’s independence and self-determination reaches. On the other hand, he/she has professional knowledge and experience. This does not necessarily mean that the patient is to remain in bed. Immobilization can lead to thrombosis, problems with lungs, and pain. If the nurse in these situations persuades the patient to get out of bed, this might be a morally responsible execution of power for the good of the patient, and the relationship builds in connected, equal cooperation. To be able to see what is at stake and what that means to the patient is to see what is morally going on and makes it clearer.

It is a difficult tightrope walk; if the nurse is bound more by rules and principles instead of letting his/her professional judgment prevail, the balance of power becomes morally irresponsible and paternalistic. Rules or programs for rehabilitation can become so rigid that the nurse is blind to the patient’s actual situation, for example, if the nurse follows the program no matter what and therefore wants the patient with a heart attack to get
out of bed. Perhaps the nurse fails to see the patient’s cyanosis. The nurse might also fail to see that the patient has developed a serious case of pneumonia.

**Trust and Honesty**

Trust also affects other principles, such as honesty, that are important in the way that the patient experiences safety in the actual situation. The patient delivers himself/herself with the body and personal information; often having conditions of which members of his family have no knowledge. Basically, the patient trusts information being used for his/her sake, for his/her own good. On the basis of the trusting relationship, the patient expects an honest nurse. But what is honesty? Trust is an ambiguous concept for a seriously ill patient.

I have experienced different opinions about trust among other professionals on truth. It is important to agree with other professionals that truth must be said at any cost. But what is the truth? And should the patient be asked? Is the nurse dishonest if he/she does not tell the truth?

Truth and openness in the concrete situation can help the patient to be open and receptive in the relationship. However, openness is not to be understood as indiscretion because a confrontation with a gloomy answer can extinguish all hope, which in some people is more valuable than the truth. Therefore, not always required to tell the whole truth may be acceptable, if the patient verbally or non-verbally indicates not wanting to know.

A characteristic of a life as a human being is that there is no final answer. There is no general theory on the dilemma of truth, but weighing the patient’s life values in light of the nurse’s values must be a part of these complex situations. Is it not about acting on the patient’s basis of existence instead of acting on the nurse’s values?

With love and trust as manifestations of life, nursing becomes a work of mercy, and mercy is active compassion attached to practical action. The concrete expression in nursing is an obligating mercy, conditioned by the practical situation of the patient and the character of the act of giving (Delmar et al., 2005).

**The Practical Care – in Concrete Situations**

The practical belongs in both everyday life and in nursing, which is why in the beginning of this section I do not differentiate between the universal and the philosophy of nursing. The substitute act which I mention at the end of this section is more associated with the philosophy of nursing.

**The Duality of a Situation**

The ethic shows itself in our actions in concrete situations, and understanding a situation is necessary to the management of power in relationship. Løgstrup’s and Martinsen’s ontological situation ethics are presented by emphasizing connection in the duality of the situation: It is typical; there are typical features of relationships. The manifestations of life are such typical features. But the situation is also unique, meaning that the irreversibility of time does not allow the same situation to occur. Thus, it is not merely a criticism of the rules and the dominance of principles in the ethics, but also a criticism of existential situation ethics, which only emphasizes the uniqueness of the situation (Martinsen, 1993, p. 72).

The concrete is not only decided by situations, but also multitudinous and varied. The concrete is also continuous and complicated in its living presence (Martinsen, 1993, p. 46). All concrete, practical issues have unifying opposites within, as an expression that the practical is ambiguous, e.g., proximity and distance as unifying opposites. Moreover, we are independent and different people who relate to each other in our independence (Martinsen, p. 37).

The practical is ambiguous. A situation is complex and often problematic and never decided by love alone. Love in itself shall not be substantiated, but how we act in relation to love must be explained and substantiated (Martinsen, 1993, p. 77). The practical expression of love must be substantiated by interpreting our basic life-experiences (Martinsen, 1993, p. 110). It is from those situations we have experiences that we can understand.

Understanding and acting on the duality of the situation means understanding the typical in the individual. The typical is the manifestations of life, the typical features of relationships which show themselves in a unique way in the concrete situation. Based on what we share as human beings, we will see the special person (Martinsen, 1993, p. 45). The special, exceptional, or unique person is the typical manifestations of life which shows itself differently (Martinsen, 1993, p. 96).

**Substituting Action**

The human interaction in nursing is what Martinsen calls substituting action. Substitution is not replacement. It is temporarily helping the patient back to his/her own place. The patient is an individual, who in a good relationship is temporarily relieved, but the patient is not removed from his/her own place (Martinsen, 1993, p. 64, pp. 155-56).

The substituting act will essentially try to promote the love of life in the patient’s suffering. The patient in the exposure of life has a life affirming view on life (Martinsen, 1993, pp. 138-39, p. 155).

**Interpretation of the Philosophy and the Impact on Nursing**

In every situation in the substituting act, the nurse must display the ability to be present in the unifying contrast between proximity and distance and confidentiality and alienation. One cannot give guidelines on that. When in the phase of establishing a relationship, the first encounter between nurse and patient is significant to their further cooperation and from which trust may grow. A clarification of expectations and roles is important, and it is important to respect that not all patients are interested in too much involvement. Many elderly may
not wish to be consulted; the nurse must respect this, but not as an abuse of power.

If the nurse is sincerely interested and committed to understanding and orienting the patient, he/she can begin at a good starting point for using spontaneous manifestations of life and professional assessment to find ways to help the patient during suffering. Spontaneous and universal love is always present.

It may be easy to simplify nursing situations theoretically, but clinical examples show how each situation represents an ethical demand and challenge. All of the nurse’s work demands a foundation of general, nursing professional knowledge. In order for the nurse to manage power in a morally responsible way, understanding a situation is prerequisite, because care shows its true colors in practice. For the nurse to obtain greater knowledge concerning specific situations, experiences from which the nurse has learned in similar situations are essential to recognize the typical and common in unique situations. The typical and common are manifestations of life, but the common can also be that which characterizes life as a human being, including phenomena such as life and death, loneliness, loss, fear, and pain. The nurse’s ability to have insight takes shape in his/her recognizing something in the situation. Recognition is obtained through practical skills and courage to be in the situation (Thorup et al., 2012) precisely because there is no moral statute book.

If the nurse is too vulnerable in the situation and cannot live out the manifestations of life, perhaps it is because he/she is facing a patient who has injured another human being. Love as an idea is constituted as principles and norms; for example, the ethical code for nurses of the International Council of Nurses. These are imposed on the nurse to carry out nursing acts with respect for human values. The problem is, however, that principles and norms can have a tendency to lose their foothold in the concrete, as in the case of the cyanotic patient, the nurse is blind to the actual situation.

**Conclusion – Becoming Whole**

Kari Martinsen’s phenomenological philosophy of care is to be understood as a framework to reflect and connect to its impact on nursing. Relationship-based caring, grounded in love and trust, is the essence of good clinical nursing practice.

The connected relationships, the moral, and the practical in care are to be understood in the light of each other. Put very briefly, the matter is about nursing as a relationship-based, moral practice, with care, love, and trust as grounded values. It is an ethical claim that in the asymmetrical nurse-patient relationship the nurse takes care of life, which alongside trust and power is placed in the hands of the nurse. Taking care of means that the nurse acts and will try to promote a life affirming view of existence in the patient’s suffering, in situations where the patient has a difficult time.

Nursing as a moral practice is also a practical issue where the activity unfolds in concrete situations. Therefore, it is also work where many different factors can change trusting relationships and nursing can freeze in negative guardianship or clinging, thereby narrowing the patient’s space of action.

Becoming whole, nursing practice, and a philosophy of care are to be understood as intertwined, and clinical nurses have to be aware of the distrusting challenges and to act in the schism between normative good care and concrete nursing situations.

**References**


Becoming Whole: Kari Martinsen's Philosophy of Care – Selected Concepts and Impact on Clinical Nursing


---

**Author Note**

Charlotte Delmar, PhD, MSN, RN, Diploma in Teaching and Education, Professor in Clinical Nursing Science, Section of Nursing, Institute of Public Health and Institute of Clinical Medicine, Aarhus University, Denmark.

Correspondence concerning this article should be electronically mailed via the Internet to: cd@sygeplejevid.au.dk

I would like to honor Professor Emerita, Kari Martinsen, Norway for being my mentor for 21 years.
Designing a Fourth Year Baccalaureate Nursing Course Utilizing the Lens of The Theory of Bureaucratic Caring and a Root Cause Analysis Approach

Colleen Maykut, RN, DNP and Lisa McKendrick-Calder, RN, MN
MacEwan University

Abstract
The purpose of baccalaureate nursing education is to foster critical thinking in the nursing student to encourage use of evidence in their practice, increasing their ability to manage complexity in a variety of settings. Nurses who incorporate critical thinking and problem-solving strategies into their practice ensure an evidence-informed approach and become active participants and architects of their own destiny. A root cause analysis approach utilizing The Theory of Bureaucratic Caring as a lens might facilitate critical thinking and problem solving, and enhance the understanding of the dichotomy of a caring bureaucracy; facilitate decision-making; and humanize nursing care (Ray, 1989; Ray & Turkel, 2012, 2010) for the nursing student.

Key Words: bureaucracy, caring, nursing students, theory, teaching strategy

Introduction
The Canadian healthcare system is a multifaceted organizational culture as a result of contextual factors (Kapiriri, Norheim & Martin, 2006) which may affect both the nursing profession and in turn, health outcomes for patients. But who is in the driver’s seat? As nursing students, the necessity to understand this organizational culture is critical to begin to co-create solutions for emerging issues and trends within the complexity of nurses’ work environments to promote a positive paradigm shift in healthcare (Sherwood, 2010; Ray, 1998). Without a clear understanding of these contexts, at first glance healthcare trends, such as the nursing shortage, may appear to have straightforward solutions. On further exploration, the complexity of this trend dictates that there is not a simple answer to the problem. The questions we ask and the decisions we implement as nurses should be grounded in best practice and human caring.

Although this article is written from a Canadian perspective, we believe the struggles for quality healthcare delivery are universal. Even though the Canadian healthcare system is predominantly a publicly funded entity, a dichotomy exists between providing basic services to all and cost containment (Kapiriri et al., 2006). We believe, regardless of the funding model, this dichotomy would exist and increase the complexity of nursing practice. This complexity results in a struggle between what one wants to do for nursing care and what one is constrained to perform based on this imposed cost containment (Kapiriri et al., 2006; Turkel, 2001; Turkel & Ray, 2001).

Nurses who incorporate critical thinking and problem-solving strategies into their practice ensure an evidence-informed approach and become active participants (Rycroft-Malone, 2008) and architects of their own destiny. A root cause analysis approach utilizing The Theory of Bureaucratic Caring as a lens should facilitate critical thinking and problem solving, and enhance the understanding of the dichotomy of a caring bureaucracy; facilitate decision-making; and humanize nursing care (Ray, 1989; Ray & Turkel, 2012, 2010; Sherwood, 2010) for the nursing student.

The authors will discuss the intentional integration of a nursing theory, grounded in caring science, to guide a root cause analysis approach to examine multiple factors currently influencing both healthcare trends, emerging issues, and the discipline and profession of nursing in Canada. The intent of incorporating Ray’s theory and root cause analysis (RCA) is to facilitate a deeper understanding for the nursing student on the complexity of the Canadian healthcare system and the effect the system has on the role of the registered nurse. A survey was performed to determine the efficacy of this approach. The major intent of this article is to add to the body of existing nursing knowledge with respect to application of theories and practice, consistent with Boyer’s (1990) definition of scholarship of teaching and learning.

Background
The Theory of Bureaucratic Caring
Ray (1989) in her sentinel article introducing the Theory of Bureaucratic Caring sounded the call that the nursing profession must recognize and respond to a healthcare bureaucracy paradoxically mandated to promote the health of Americans. Twenty-three years have passed and some would argue that there is still a paradoxical struggle among health, care, and organizational culture (healthcare system) of bureaucracy. Ray’s initial research was to discern how caring was expressed in a complex organizational structure (hospital) with proposed initiatives for administrators to demonstrate caring actions. “The formal Theory of Bureaucratic Caring was a result of a dialectical synthesis between the thesis
of caring as humanistic, social, educational, ethical, and religious/spiritual and the antithesis of caring as economic, political, legal, and technological” (Ray, 1989, p. 39). These interconnected dimensions not only influence an organizational culture’s decision-making, but offer clarity and perspectives for nurses to enhance caring as a way of being in their practice.

**Root Cause Analysis Approach**

A root cause analysis (RCA) approach analyzes factors to improve critical thinking which should enhance patient care (Lambton & Mahlmeister, 2009; Sherwood, 2010; Tschannen, & Aebersold, 2010). The underlying premise of RCA is that problems require an upstream approach resolution which would identify and eliminate the root causes instead of concentrating only on the consequences: a downstream or Band-Aid approach (Sherwood, 2010). As there might be more than one root cause, a detailed investigation examining multiple influencing factors is warranted to ensure a comprehensive conclusion. However, individuals may only examine the problem superficially and design solutions which fix the symptoms (what lies on the surface) temporarily and are left with a reoccurring problem. Although RCA is usually utilized as a reactive approach (an error has already occurred), this methodology was introduced to analyze and then anticipate potential solutions following a detailed examination through multiple lenses from the Theory of Bureaucratic Caring, by the baccalaureate nursing student. There was no published literature located that utilizes this collaborative approach in nursing education as a teaching strategy. Therefore, designing a unique collaboration between a root cause analysis as an analytical approach and the Theory of Bureaucratic Caring as a framework to facilitate understanding of the complexity of emerging issues and trends in Canadian healthcare might be beneficial for baccalaureate nursing education.

**Baccalaureate Nursing Education**

The purpose of baccalaureate nursing education is to foster critical thinking in nursing students to encourage use of evidence in their practice and increase their ability to manage complexity in a variety of settings (Wangensteen, Johansson, Björkström, & Nordström, 2010). The goal of baccalaureate nursing education in Canada is to provide the graduate with a skill set (psychomotor, cognitive, and affective) to address: the numerous nursing practice settings; the needs of a diverse Canadian population (cultural, socio-economic, political, and educational); the necessity for life-long learning including advanced nursing education; and the appropriate utilization of technology and resources to ensure safe, competent, and ethical care (Canadian Association of Schools of Nursing, 2011; Canadian Nursing Association, 2011). The purpose of higher education is to provide graduates with opportunities to develop the ability to think critically; to define the problem contextually, to ask higher-order questions; to examine underlying beliefs prior to determining inferences, while maintaining an attitude of inquiry (Miri, David, & Uri, 2007; Wangensteen et al., 2010). Therefore, nurse educators must design and implement evaluative components that shift their focus from rote-learning to exploring potential/actual problems (Profetto-McGrath, 2003; Vacek, 2009). Utilizing a critical thinking approach in evaluative components encourages the development of high-order thinking and disposition in nursing students (Profetto-McGrath, 2003) and may assist implementation of an evidence-informed approach to nursing care (Rycroft-Malone, 2008) to assist in transition to graduate practice.

**Designing a Fourth Year Baccalaureate Nursing Course Utilizing a Caring Theory and a Root Cause Analysis Approach**

**Setting**

MacEwan University is an undergraduate educational institution with a primary focus on teaching, situated in Edmonton, Alberta, Canada. The Bachelor of Science in Nursing degree is a four-year program with approximately 1,300 students enrolled at any given time. Each year of the program is composed of one term of theory followed by a term of clinical placements; knowledge acquisition precedes practice.

**Course Description**

“Future Directions in Nursing” is a 45-hour required course in the fourth year theory term of the program; two thirds of the course is faculty-led with the remaining reserved for group teaching presentations. One of the intentions of this course is to assist students to develop an awareness of how trends and emerging issues from a provincial, federal, and global perspective influence the healthcare system, our professional practice, and the discipline of nursing. The two main evaluative components of this course are a group teaching presentation and a peer-reviewed scholarly paper. Both components require the student to include three relevant concepts from the Theory of Bureaucratic Caring to examine in depth (root cause analysis) the multiple factors influencing the trend or issue and the profession of nursing as well as to provide evidence-informed recommendations.

**Course Design**

Faculty introduce the Theory of Bureaucratic Caring to the students in a ½ hour class at the beginning of the term. An example of how a class would be structured utilizing Ray’s theory and a RCA approach is highlighted with the following topic, “Is the Canadian Healthcare System Sustainable?” The concept of economics from the theory is explored both in depth and breadth, providing clarity and
application for the students. Students are expected to articulate system issues locally, provincially, and federally with respect to Ray’s dimension of economics. A discussion regarding “economics” would focus on both scarce human and non-human resources and the challenge to balance budgets while ensuring quality health programming for all citizens: caring in action. A RCA approach would utilize information from multiple sources (peer-reviewed, grey literature, and mass media) to facilitate critical thinking to identify and eliminate the root causes instead of concentrating only on the consequences, therefore, fostering an upstream approach for the creation of potential solutions.

Students are also expected to describe how decision-making and uses of power (political dimension) influence healthcare decisions. Of additional interest would be the exploration of the RNs’ accountability, responsibility, rules, and principles to guide nursing actions (legal dimension) and the expression for human potential (social dimension) within our nursing practice. Consequently, faculty-led classes highlight a minimum of one dimension from the theory per topic while applying the other dimensions. Other topics of interest covered in this course include but are not limited to genomics, cause-related marketing, and social media.

Ethical Considerations

The Research Ethics Board at MacEwan University reviewed and approved the faculty request to gather feedback to inform the course design. Of interest to the faculty was (a) determine the efficacy of the Theory of Bureaucratic Caring as pedagogical framework to facilitate understanding of the complexity of current trends and emerging issues affecting the Canadian healthcare system and the practice of nursing; and (b) to verify if the nursing student’s future decision-making practices may be enhanced. The feedback was collected in the form of a survey which included: (a) a 4-point Likert scale (Strongly Agree, Agree, Disagree, and Strongly Disagree); (b) an opportunity to provide further elaboration regarding the question; and (c) a demographic data instrument. The survey utilized the platform “Survey Monkey” to ensure greater anonymity than what would be provided by Blackboard (the learning management software program used by the university).

Findings

Demographics

A purposive convenience sample approach was chosen to elicit feedback from all 72 students enrolled in both the fall 2011 and winter 2012 terms taught by the authors. The authors were familiar with the nursing students, the Theory of Bureaucratic Caring, and the course’s purposes. A vast majority of the respondents (73%) are currently or have been employed in Alberta’s healthcare system. Most students apply to work as undergraduate nursing employees on completion of the third year of MacEwan’s program.

Student Feedback

Overall, students found that the collaborative approach allowed them to identify the complexity within the trend or issue (45.5%, agree; 45.5%, strongly agree). Ray’s eight concepts were clearly defined and simple to both understand and apply during classroom discussion, teaching presentations, and in the development of their scholarly paper. Nine students (81.8%) agreed they would utilize Ray’s theory as a framework to analyze trends/issues in their future practice.

Finally, all students responded that this approach should continue in future course offerings as it facilitates appreciation for the complexity not visibly seen upon superficial examination as noted in the following direct quotes: “Caring is a multidimensional and complex concept – I think the model removes some of the fluffiness which is associated with caring and puts it into context for the nursing profession and complex healthcare system”; “I didn’t realize all the external factors influencing both the nursing profession and the healthcare system.

Discussion

The gap between theory and practice has been identified as a concern in the profession of nursing. An opportunity for application of new knowledge is essential to ensure comprehension, especially in the classroom. The role of the educator is to provide relevant strategies to assist with application of new knowledge in such a way as to bridge the theory practice gap as identified in Boyer’s (1990) Scholarship of Teaching and Learning. The nursing
student’s future decision-making practices may be enhanced by utilizing a contextual framework (theory) to explore the complexity of the current healthcare system and organizational culture (practice). Results gathered from student feedback confirm that the introduction of a collaborative approach utilizing Ray’s (1989) Theory of Bureaucratic Caring and a RCA as a teaching strategy was viewed predominantly as a positive endeavor in which to engage nursing students in the classroom. The vast majority of the students who provided feedback indicated that both this theory and RCA assisted them in clarifying the relevant concepts within their trend paper and during their group teaching presentation. The overwhelming response (100% strongly agreed) to the question of “Would you recommend this teaching strategy in future offerings of this course, why or why not?” suggests that this teaching strategy is both relevant and offers a concrete (clear definitions of concepts) approach to allow the nursing student to deepen and broaden their understanding of current trends and emerging issues affecting the Canadian healthcare system and effects on the nursing profession. The utilization of Theory of Bureaucratic Caring as a teaching strategy was not used previously; this study adds to the body of nursing knowledge.

Implications for Educational Practice
Ray and Turkel have both singularly and collaboratively discussed bureaucracy/economics and nursing practice within cultural organizations. However, to date in a review of published literature, Ray’s (1989) original theory integrated with a RCA approach has not been utilized as a teaching strategy in nursing education to emphasize the linkages between theory and practice. The relevance and significance of this course design for the discipline of nursing lies in the effectiveness of utilizing Ray’s theoretical framework to facilitate understanding of the complexity of the healthcare system with respect to the profession of nursing. The expectation is that the Theory of Bureaucratic Caring and RCA approach may be utilized as a framework in the classroom to facilitate deeper exploration of the complexity of current trends and emerging issues in the healthcare system currently affecting the profession of nursing.

Implications for Research
Nurse educators must understand the importance of utilizing teaching strategies and creating evaluative components (the Scholarship of Teaching and Learning) in nursing education that assist in the development of critical thinking skills and disposition in our nursing students. Developing and evaluating teaching strategies in the classroom is essential to narrow the theory-practice gap and also to assess the relevance of the educational experience from the learner’s perspective. Recognizing the need to graduate nursing students with the ability to apply theoretical content in a variety of situations, nurse educators need to ensure learning experiences are relevant for current and future practice. Research could utilize focus groups to provide richness of qualitative findings to complement and enhance feedback retrieved during this course design.

Conclusion
Competing values of bureaucracy (economic, political, legal, and technological) and caring (humanistic, social, educational, ethical, and religious/spiritual) currently exist in the healthcare system and both influence the work of nurses (Ray, 1989, 1998; Ray & Turkel, 2012, 2010). Nurses need to recognize the notion of health as a way of becoming and facilitate this process in the work we do (Greenhalgh, Vanhanen, & Kyngäs, 1998; Ray, 1989, 1998; Ray & Turkel, 2012, 2010). We need to ensure that healthcare delivery is not at the expense of efficiency and quality with the potential outcome of a devaluation of nursing (Turkel & Ray, 2000), but find a balance between the realities of finances and humanistic care (Turkel, 2001). A caritas nursing manifesto ultimately “…must redefine itself in terms of economics in relation to its traditional values of caring, quality, and patient advocacy” (Turkel & Ray, 2001, p. 284).

Nurses need to be aware of the complexity of organizational structures which affect their work to be able to articulate resources necessary to ensure competent, ethical, and safe nursing care. As advocates for both our patients (individually) and for healthcare reform (collectively), we need to assume our role in leading initiatives that focus on both levels. We need to learn with and from our peers to co-create partnerships to improve communication and organizational practices to facilitate a healthy environment which in turn may enhance patient outcomes and ensure authenticity for ourselves (Turkel & Ray, 2004).

Nursing students need to understand the complexity of organizational cultures and the dichotomy between caring and economics to become active participants at their place of employment as well as advocates in the larger healthcare schemata. The Theory of Bureaucratic Caring offers a viable framework to broaden and deepen the nursing student’s appreciation for this complexity. This appreciation may enhance the being, knowing, and doing of the nursing student as they come to understand caring as complex and allow for every moment to enhance healing both for the nursed and the nurse (Turkel, 2001).

References
Designing a Fourth Year Baccalaureate Nursing Course


Designing a Fourth Year Baccalaureate Nursing Course

Author Note

Colleen Maykut, RN, DNP, Assistant Professor; Lisa McKendrick-Calder, RN, BSN, MN, Nursing Faculty, MacEwan University, Bachelor of Science in Nursing Program, Edmonton, Alberta, Canada T5J 4S2.

Correspondence concerning this article should be addressed to Dr. Colleen Maykut, MacEwan University, Bachelor of Science in Nursing Program, 9-507G, 10700-104 Avenue Edmonton, Alberta, Canada T5J 4S2. Electronic mail may be sent via Internet to maykutc@macewan.ca
Mentoring Clinical Adjunct Nursing Faculty
Mary Lou Gies, EdD, MSN, RN
La Salle University

Abstract
Mentoring is a recognized means of enlisting and retaining employees in a profession. Expert nursing clinicians often begin in an educator’s role as adjunct faculty, at remote clinical settings that could deprive them of information critical for a successful start. Their job satisfaction may be threatened by unclear expectations of administrators. Novice nursing faculty can benefit from being part of a well-thought-out mentoring program. This review of the literature on mentoring of clinical adjunct faculty reveals that there is a minimal amount of information on their specific needs. The literature available identifies the benefits and vital components of a mentoring program. Use of these strategic methods to initiate a mentoring program could facilitate new initiatives for clinical adjunct nursing faculty success.

Keywords: mentoring, nursing, adjunct faculty

Mentoring Clinical Adjunct Nursing Faculty

The shortage of nursing faculty nationwide has reached significant levels (Cangelosi, 2006). The average age of nursing faculty teaching in graduate and baccalaureate programs is 51.5 years. Soon, the rate of retirement will exceed the rate of replacements. Adding to the dilemma, faculty salaries have not increased at the same pace as clinical positions because university budget constraints have not allowed institutions to offer salaries that are competitive. In addition, take-home work, course planning, supervising students, and loss of personal time were cited as disadvantages of the faculty job (Tanner, 2006).

Many colleges and universities have hired increasing numbers of adjunct faculty. Adjunct faculty numbers have steadily increased over the last 10 years. In 2007, there were 667,927 adjunct faculty members in the United States as compared to 421,094 in 1997 (U.S. Department of Education, 2007). In an effort to control costs by not offering adjunct faculty benefits, this group of faculty has been hired in record numbers. Because of their practical experiences and clinical backgrounds, adjunct nursing faculty members often teach in clinical settings. In such settings, their contributions to nursing education have been described by students as invaluable and as making a critical difference in applying classroom learning during their clinical experiences (Cangelosi, 2007).

Although adjunct faculty members may be productive and enjoy their work, Green (2007) reported that they feel disconnected and unappreciated. They may lack instructional knowledge and contextual information about the university’s mission, values, and beliefs (Peters & Boylston, 2006). This faculty group articulated frustration and stress in transitioning from expert clinician to an educator role.

Mentoring: Benefits and Programs
Mentoring in nursing can make a difference in many areas of the healthcare field. A mentored nurse educator may become an empowered, involved leader. The nurse leader can affect patient outcomes, delivery of care, and organizational change. In contrast, the expert clinical nurse educator can shape many nursing careers.

The mentor enhances a mentee’s knowledge of the academic landscape. This seasoned employee increases the mentee’s confidence, depth of thinking, communication, and collaboration skills (Grossman, 2007).

Within the context of adjunct faculty preparations, Boyden (2000) and Velianoff (2003) identified unique strategies to aid in the development and retention of nursing faculty. Some of the suggestions for recruitment and retention of nurse educators were (a) orientation with an opportunity to build relationships, (b) mentoring, (c) support for research and scholarship, (d) instructional technology guidance, (e) electronic communication, (f) sessions on role strain, and (g) balancing academic, personal, and scholarship needs.

West et al. (2009) aimed to improve the student’s clinical experience by increasing the clinical faculty’s job satisfaction. Proposed solutions for administrators were to (a) provide workshops, (b) develop collaboration between hospitals and universities, (c) initiate a mentoring program, and (d) incorporate technology into faculty development. A successful mentoring program might allow the mentor to share successful teaching behaviors and suggest how to discourage inappropriate behaviors when supervising students in clinical settings. These recommendations provided insights into the lack of preparation of adjunct faculty members and possible reasons for their limited success and satisfaction in instructional roles.

Adjunct faculty member predictors that influence satisfaction in the educator’s role are: (a) autonomy, (b) teacher schedule, (c) pay, (d) work preference, (e) faculty support, (f) recognition, (g) status, (h) quality of students, and (i) job security (Howell & Hoyt, 2007), all of which are
related to institutional working conditions. These factors should be considered when employing adjunct faculty. Gormley (2003) named unclear expectations of the dean or director concerning the curriculum and instruction as a source of adjunct faculty dissatisfaction. New employees may not be familiar with the mission, goals, vision, expectations, and values of the institution. Consequently, adjunct faculty members also have unique needs that require socialization and integration into a new career to facilitate success.

Teacher satisfaction has also been linked to retention, commitment, and contribution to the school’s effectiveness (Woods & Weasmer, 2002). The lack of contact with administration and full-time faculty can lead to high attrition rates among new faculty (Maxey-Gibbs, 2005). A consistent pool of adjunct nursing faculty might benefit student learning and the institution’s mission.

Successful mentoring has been found to have a widespread effect on nursing practice. Improvements to nursing clinical practice from mentoring may include areas of professional growth, increased competencies, and improved productivity levels for master’s prepared or advanced-practice nurses (Barker, 2006). Mentors may also benefit from the satisfaction of giving back to the profession and seeing mentees become successful. Mentors gain job satisfaction from witnessing the development of their mentees. The role allows them to convey the extensive knowledge they amassed over their academic career. By gaining a fresh perspective, mentors’ careers may develop and purposes of a mentoring relationship can benefit from understanding the phases of the classic mentoring relationship: (a) initiation, (b) cultivation, (c) separation, and (d) redefinition. At the initiation stage, mentors and mentees meet and connect by

**Mentoring Clinical Adjunct Nursing Faculty**

faculty members in their new roles (Dunham-Taylor, Moore, McDaniel, & Walker, 2008). Role modeling has been shown to be effective by assisting in the development or learning of new behaviors, which can be easily imitated by the mentee.

Through experiential learning, role models helped to effect change in new educators (Grossman, 2007). In experiential learning situations, the coaching roles of mentors were beneficial to mentees, who may have been trained, but who still needed direction or confidence-building learning experiences. Effective mentors offer support for the mentees by offering ideas and acting as sounding boards, specifically to work on weaknesses. The mentors, as coaches, can encourage assertiveness, teach methods of managing conflict, and provide ways to solve organizational problems.

Because there are many differences in the clinical setting and in academic settings, the transition from clinician to educator could be smoother with the assistance of a mentor who already understands what is required to be successful. Although the values and importance of issues may differ throughout the broad culture of universities, the need to set aside time to read, write, and process information remains important in academic settings (DiGiacomo, 2007). In addition, clinical educators must provide a safe environment that allows students to learn from mistakes and to celebrate learning successes (Hayes, 2005). Novice educators should know that their new role will require them to facilitate and foster an open, respectful learning atmosphere for students.

**Mentoring Strategies and Process**

The success of mentoring programs in other disciplines could also prove successful for the education of nurses and nursing instructors. One primary purpose of nurse educator mentoring programs has been to aid the nurse clinician’s role transition from practitioner to instructor. Sawatzky and Enns (2009) found that the most significant stressor for novice nursing faculty members involved difficulties fitting into academic settings and learning how to improve their teaching expertise. Typically, novice faculty members were almost universally unaware of the expectations in their new role. However, even when mentoring programs were available to help transition clinicians, mentees often reported the need to know that their mentors cared about their success as new instructors.

Hayes (2005) suggested that there are phases to the mentoring process that will help the mentor and mentee better understand the roles and responsibilities within the mentoring relationship. The early phases include planning; developing trust; exploring possibilities, roles and responsibilities; beginning the mentoring experience; and dealing with potential conflict. Newer mentors might also experience role shock and feelings of self-doubt in their new roles as mentors. Similarly, mentees might also be concerned with survival, safety, self-esteem needs, and belonging. However, Hayes found that new mentors quickly recovered from their insecurities and became more confident in their mentoring role when they saw evidence of mentee success and growth.

The middle phase of the mentoring relationship allows the mentee to assume responsibility and proceed independently while acting under the guidance of the mentor. Hayes (2005) stated that during the final phases reflections are on accomplishments, mentee proficiency and competence, and self-actualization of both mentor and mentee. The final phase of a mentoring relationship may lead to a collegial link and friendship. Mentors can benefit from understanding the phases and purposes of a mentoring relationship in order to support mentees’ progress.

All relationships, including mentoring relationships, change over time. To illustrate, Grossman (2007) reviewed mentoring theory and acknowledged Kram’s stages of the classic mentoring relationship: (a) initiation, (b) cultivation, (c) separation, and (d) redefinition. At the initiation stage, mentors and mentees meet and connect by
identifying similarities. The second phase, cultivation, is when career development, resource exchange, and learning occur. Separation of the mentor and mentee is usually spontaneous when the mentee becomes autonomous. The redefinition stage can change to a collegial or friendly relationship.

Zachary (2009) has written extensively about mentoring and addressing the needs of mentors and mentees while examining how to develop and sustain an effective culture of mentoring. Zachary named four stages of mentoring. The first stage should be one of exploring the framework of the mentoring relationship, where the mentees and mentors should honestly examine their motivations and expectations for the mentoring process. The second stage, or negotiating, is one that establishes the agreements between the mentee and the mentor. Trust and confidentiality must be established early and is critical to mentoring success and an essential foundational element for any successful mentoring relationship. The third stage, or enabling, is described as the work phase in which the actual mentoring activities and mentee learning takes place (Zachary, 2009). The primary objective of this stage focuses on implementing and accomplishing the planned goals of the relationship. The fourth and final stage is closure, which requires (a) evaluating the partnership, (b) identifying the results, (c) celebrating any successes, and (d) ending the mentoring contract formally. Zachary (2000, 2009) also noted that it is essential that the mentoring have a defined end, even though a collegial and more informal relationship may continue. The goal of mentoring is achieving the successful and productive independence of the mentee.

From the larger context of managing a mentoring program, the importance of cultivating a mentoring culture has been proven essential to any effective mentoring program (Zachary, 2005). The organizational culture should create reward, recognition, and celebration for mentoring. Discussion guides should facilitate and help develop what kinds of education and training are needed for both mentors and mentees. The organization’s guide or mentoring handbook should also consider the details of the mentoring foundation and the process necessary for the positive progression of the program.

Mentoring programs had been utilized as a means of improving recruitment, retention, teaching effectiveness, and satisfaction for recently hired faculty. Many professions implemented this method of orienting and inculcating new employees into an organization. Such programs have successfully increased employee effectiveness, accelerated the speed of employee success, and assisted with higher levels of employee engagement, all of which can facilitate the integration of the new instructor into the learning community.

Critical Components of a Successful Program
Mentors identified ways that mentors can assist them in their transition. Mentoring program themes of orientation, support, and follow-up emerged in the review of the literature (see Table 1). Implementation of these themes is outlined and provides a means of developing a successful nursing mentoring program. Topics to be covered during the transition period include policies and procedures, course expectations, and opportunities for professional development (Peters & Boylston, 2006). Mentees named activities that were helpful during the faculty’s first year. The most helpful activities were the mentors being available, providing feedback on teaching, and providing help with operationalizing teaching responsibilities (Sharbaugh, 2000). Mentees might expect that, because of mentoring, their first year as faculty members may produce a more positive learning outcome for the students and an increased level of job satisfaction for themselves.

As an essential supplement to mentoring programs, a handbook for new faculty has also been shown to be beneficial. At the University of Scranton, experienced faculty recognized a greater need to orient clinical faculty because adjuncts had fewer opportunities to contact the school and colleagues. Therefore, a department-specific handbook was developed as a reference that assisted with orienting faculty (Pierangeli, 2006). Research showed that this handbook was an effective tool that provided new faculty with valuable resource materials during the early training of new full-time faculty and adjuncts.

In addition to creating a handbook of mentoring instructions, Reese (2000) spelled out specific details of effective mentoring program operations. Recruiting, screening, and orienting mentors and mentees were considered the basis of strong, everyday operations. Matching mentors and mentees and offering ongoing support, supervision, and monitoring were recommended as essential components. Reese also found that recognizing participants’ contributions to the program was a vital component in the operations piece of the mentoring program. All elements of the program needed regular evaluation and monitoring to ensure quality and effectiveness by measuring actual and expected program outcomes and processes.

A mentoring program should address the shared needs of the mentor, mentee, and administrators of an institution. The mentor may have a desire to convey the breadth of knowledge gained, with the determination to strengthen the organization’s culture from years of clinical teaching. They may want to watch a novice grow into a successful, seasoned faculty member. The mentee may not have a teaching background but a strong desire to acquire the skill set needed to develop student nurses into the profession. Administrators aspire to drive successful outcomes by positively enhancing the student experience and may require mentees to participate in a structured program, to ensure consistent educational standards of a respected, accredited program. They know the importance of valuable clinical experiences in a practice profession that enhance the probability of positive student outcomes. The structured expectations of the
### Table 1

*Mentoring Program Essentials*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Authors</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting a program</td>
<td>Boyden, 2000</td>
<td>• Recruit and screen mentors</td>
</tr>
<tr>
<td></td>
<td>Reese, 2000</td>
<td>• Orient mentors and mentees to the program</td>
</tr>
<tr>
<td></td>
<td>Velianoff, 2003</td>
<td>• Match mentor and mentee based on clinical site, course, and/or home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Build relationships</td>
</tr>
<tr>
<td>Workshops on:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Successful teaching strategies</td>
<td>West, et al., 2009</td>
<td>• Provide adjunct faculty-specific development programs</td>
</tr>
<tr>
<td>• How to address inappropriate behavior when supervising clinical groups</td>
<td>Peters &amp; Boyleston, 2006</td>
<td></td>
</tr>
<tr>
<td>• Instructional and campus technology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Role strain: balancing academic, personal, and scholarship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set expectations</td>
<td>Gormley, 2003</td>
<td>• Checklist of vital discussion topics</td>
</tr>
<tr>
<td></td>
<td>Sawatzky &amp; Enns, 2009</td>
<td>Mentor and mentee schedule meeting times and days, considering hospital orientation and student evaluations</td>
</tr>
<tr>
<td>Role model</td>
<td>Grossman, 2007</td>
<td>• Role play or shadow a clinical instructor during a clinical day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Offer ideas and act a sounding board</td>
</tr>
<tr>
<td>Policies and procedures</td>
<td>Peters &amp; Boyleston, 2006</td>
<td>• Provide contextual information about the university’s mission, values, and beliefs</td>
</tr>
<tr>
<td></td>
<td>Pierangeli, 2006</td>
<td>• Department-specific handbook</td>
</tr>
<tr>
<td><strong>Support:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sources of support</td>
<td>Reese, 2000</td>
<td>• Coaching</td>
</tr>
<tr>
<td></td>
<td>Howell &amp; Hoyt, 2007</td>
<td>• Collaboration between university and hospital</td>
</tr>
<tr>
<td></td>
<td>West, et al., 2009</td>
<td>• Provide contact with administration and full-time faculty</td>
</tr>
<tr>
<td></td>
<td>Maxey &amp; Gibbs, 2005</td>
<td>• How to manage conflict and organizational problems</td>
</tr>
<tr>
<td></td>
<td>Grossman, 2007</td>
<td>• Help with difficulty fitting in</td>
</tr>
<tr>
<td></td>
<td>Sawatzky &amp; Enns, 2009</td>
<td>• Provide feedback and expectations</td>
</tr>
<tr>
<td>• Operationalize teaching responsibilities</td>
<td>Sharbaugh, 2000</td>
<td>• Provide feedback and expectations</td>
</tr>
<tr>
<td></td>
<td>Sawatzky &amp; Enns, 2009</td>
<td></td>
</tr>
<tr>
<td>• Research and scholarship</td>
<td>Boyden, 2000</td>
<td>• Provide feedback and expectations</td>
</tr>
<tr>
<td></td>
<td>Velianoff, 2003</td>
<td></td>
</tr>
<tr>
<td><strong>Follow-up:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recognize mentor’s participation</td>
<td>Reese, 2000</td>
<td>• Acknowledge dedication to program</td>
</tr>
<tr>
<td>• Supervise and monitor the mentoring program</td>
<td></td>
<td>• Continuous review of program with visits to clinical sites and follow-up phone calls</td>
</tr>
<tr>
<td>• Regular evaluation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
institution’s administrators, mentors, and mentees form the basis of the mentoring relationship (Zachary, 2005).

Pairing of mentors and mentees is the administrator’s first step in building a program. These decisions could be based on course assignment, similar clinical sites, and proximity to each other’s clinical site or home, which will provide convenient meeting places. These factors facilitate face-to-face meetings of mentors and mentees, to initiate their relationship during which mutual goal setting and boundaries are established. A checklist of vital discussion topics, developed by administrators, could provide the pair with structure and content. The mentor and mentee would set up a schedule of meetings including contact times and days, that should take into account significant events such as orientation to the clinical site and evaluations.

The mentor and mentee move into the working phase of the relationship when they begin to meet each other’s goals. The mentor’s goals could consist of but not be confined to setting up faculty and student orientations, passing on knowledge of the clinical site’s policies, and how to evaluate student clinical performance. The recommended mentee goals can be meeting the expectations of the administrators and students, as well as embracing the mission and culture of the organization. The relationship may continue until the pair’s objectives are met or a determination has been made by the program manager to end or extend the program.

A variety of resources should be available to mentees, in order to ensure success in their new position. Hard copies of student and clinical faculty manuals, blank and sample forms, snow and emergency clinical cancellation policies, and a list of important phone numbers are amongst requested resources. Web-based platforms such as Blackboard could be a repository of these resources, providing ready accessibility for the mentee.

Conclusion

The success of a mentoring program starts at the administrative level (Zachary, 2005). Administrative support can drive the academic team to initiate and manage a new program, setting standards that will impact improved student outcomes, strengthen the culture, advance the mission, and enhance faculty job satisfaction. A designated program manager can follow up on day-to-day details by contacting and visiting the pairs at clinical sites and monitoring the program expectations. When these supports are in place, mentors and mentees will know they can rely on administrators as steadfast resources when clinical issues arise.

Motivation of the mentor and mentee to develop and maintain a productive relationship with defined goals aimed at ensuring constructive outcomes is the impetus to a successful program. Mutual expectations of the program should be considered, as well. Well-defined and outlined expectations delivered to the mentor and mentee by the administrator is also a key element. The individual needs of all stakeholders should be considered in the development and maintenance of a mentoring program. Level of experience, personality traits, and willingness to participate in the program are important factors when selecting the mentor/mentee pair. A well-developed and monitored mentoring program can improve teaching effectiveness, faculty job satisfaction, and positively affect the profession, student, and patient outcomes.

References


Author Note

Mary Lou Gies, EdD, MSN, RN, Assistant Professor, Nursing Programs, School of Nursing and Health Sciences, La Salle University. Correspondence concerning this article should be addressed to Mary Lou Gies, Nursing Programs, School of Nursing and Health Sciences, La Salle University, Philadelphia, PA 19141. Electronic mail may be sent via Internet to gies@lasalle.edu
34th International Association for Human Caring Conference

May 29 – June 1, 2013
Orlando, Florida

*Magic, Mystery and Miracles – Embracing the Difference Caring Makes in Nursing Practice, Education and Research*

The International Association for Human Caring provides the forum for discovery and dissemination of caring science

Walt Disney World Swan and Dolphin Resort, Epcot Resorts Boulevard, Lake Buena Vista FL

Conference Sponsored by:
Conference Objectives: At the conclusion of the conference participants will:
• Describe how to live caring as the essence of nursing in education and practice.
• Appreciate multiple ways of evaluating the difference that caring makes in nursing practice and education.
• Examine critically the evidence related to the difference that caring makes in nursing practice and education.
• Disseminate caring-based educational, practice and research approaches that make a difference to persons, families and communities.

CONFERENCE PLANNING COMMITTEE:
Andrea Berndt, PhD, MS, BS, Assistant Professor, Statistician, University of Texas Health Science Center at San Antonio School of Nursing, San Antonio, TX
Diane Breckenridge, PhD, RN, Associate Professor, School of Nursing and Health Sciences La Salle University, Philadelphia, PA
Holly Diesel, PhD, RN, Associate Professor, Goldfarb School of Nursing at Barnes-Jewish College, St. Louis, MO
Terry Eggenberger, PhD, RN, CNE, Associate Professor, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL
Donna Linette, MS RN NEA-BC LHRM, Divisional CNO, GEO Care Inc. Boca Raton, FL
Marlinee Smith, RN, PhD, AHN-BC, FAAN, Dean and Helen K. Persson Eminent Scholar, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL
Marian Turkel, PhD, RN, NEA-BC, FAAN, Director Professional Nursing Practice and Research, Einstein Healthcare Network, Philadelphia, PA
Lynne Wagner, EdD, RN, MSN, Nurse Educator/Consultant, Chelmsford, MA
Gail B. Williams, PhD, RN, PMHCNS-BC, Immediate Past President IAHC; Professor, School of Nursing, UT Health Science Center, San Antonio, TX
Carol Wilson, PhD, RN, Professor, University of West Georgia, Carrollton, GA
Jill Winland-Brown, EdD, MSN, FNP-BC, Professor, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL
Zane Robinson Wolf, PhD, RN, FAAN, Dean Emerita and Professor, School of Nursing and Health Sciences, La Salle University, Philadelphia, PA
ABSTRACT REVIEWERS (includes Planning Committee):
Charlotte Barry, PhD, RN, NCSN, Professor and Master Teacher, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL
Gayle Casterline, PhD, RN, CNE, Associate Professor, Blair College of Health, Presbyterian School of Nursing, Queens University of Charlotte, NC
Patrick J. Dean, EdD, RN, MSTJ, Clinical Assistant Professor, University of Minnesota Rochester, School of Nursing, Rochester, MN
Nancey France, PhD, RN, President-Elect IAHC, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL
Marlienne Goldin, RN, BSN, MPA, Director, Neuro ICU, Cone Health System, Greensboro, NC
Rebecca Lee, PhD, RN, PHCNS-BC, CTN-A, Assistant Professor, University of Cincinnati College of Nursing, Cincinnati, OH
Louise O’Reilly, PhD, RN, University of Sherbrooke, Campus of Longueuil, 150 Place Charles-Leitoyne, Longueuil, Quebec
Tina Roma-Fisher, RN, MSN, CRRN, Caritas Coach, Rehabilitation Coordinator, Moss Rehab at Sacred Heart, Allentown, PA
Jane Sumner, PhD, RN, PHCNS, BC, Professor of Nursing, Louisiana State University Health Sciences Center, School of Nursing, New Orleans, LA, USA

KEYNOTE SPEAKER: Anne Boykin, PhD, MN, BSN
Dr. Anne Boykin is Professor Emeritus and Director of the Anne Boykin Institute for the Advancement of Caring in Nursing in the Christine E. Lynn College of Nursing at Florida Atlantic University. She is past-President of the International Association for Human Caring. Dr. Boykin has published, researched, and consulted widely on caring in nursing. She and Dr. Savina Schoenhofer are co-authors of the theory, Nursing as Caring: A Model for Transforming Practice.

ENDNOTE SPEAKER: Jean Watson, PhD, RN, AHN-BC, FAAN
Dr. Jean Watson is Distinguished Professor and Dean Emerita, University of Colorado Denver College of Nursing and Anschutz Medical Center, where she held an endowed Chair in Caring Science for 16 years. She is founder of the original Center for Human Caring in Colorado and is a Fellow of the American Academy of Nursing. She previously served as Dean of Nursing at the University Health Sciences Center and is a Past President of the National League for Nursing. Clinical nurses and academic programs throughout the world use her published works on the philosophy and theory of human caring and the art and science of caring in nursing. Dr. Watson’s caring philosophy is used to guide transformative models of caring and healing practices for nurses and patients alike, in diverse settings worldwide.
As author/co-author of over 18 books on caring, her latest books range from empirical measurements and international research on caring, to new postmodern philosophies of caring and healing, philosophy and science of caring, and caring science as sacred science. Her books have been American Journal of Nursing books of the year awards and seek to bridge paradigms as well as point toward transformative models for this 21st century. Her latest activities include Founder and Director of the non-profit foundation: Watson Caring Science Institute. In partnership with heart science developments, she serves as Distinguished Scholar in Institute of HeartMath (www.heartmath.org).

Special Presentation:
Marilyn (Dee) Ray, RN, PhD, CTN-A
Honoring 35 Years of Caring Scholarship: Reflections from 1978

Dr. Ray, Emeritus Professor, Christine E. Lynn College of Nursing, Florida Atlantic University, has advanced qualitative human science research for years. Her interests are many, including phenomenology, philosophies of science, transcultural health care, and the philosophy of nursing and human caring. Her commitment to nursing scholarship continues as she inspires colleagues and graduate and doctoral students. Dr. Ray’s Bureaucratic Caring Theory has been cited by many, and along with many articles and books (e.g. with A. Davidson and M. Turkel, Nursing, Caring and Complexity for Human-Environment Well-Being) and her commitment to caring science, she is positioned to reflect on how far caring scholarship has come since the first meeting of caring scholars in 1978.

Dr. Ray described her involvement in the first Caring Conference. She and another doctoral student, Dolores Gaut, presented ideas and shared perspectives on caring with other luminaries, including Jean Watson and Madeleine Leininger. She learned to “speak up” then and to share her views and scholarly work as a doctoral student. Dr. Ray’s long lasting commitment to the profession of nursing, particularly transcultural nursing, caring science, and research methods, evidences a true nursing scholar.

Symposia

Symposium:
Narrative Pedagogy and the Caring Professions: Theory, Education, Research, and Practice

Sharon Ann Cumbie, PhD, RN, CS; Wendy E. Miller, DNP, RN, CNE
College of Health Sciences, Appalachian State University; Chris Osmond, PhD, College of Education, Appalachian State University; Dana E. Brackney PhD, RN, CDE, BC-ADM, College of Health Sciences, Appalachian State University, Boone, NC, USA

Symposium Introduction and Overview
Sharon Ann Cumbie, PhD, RN, CS

Temporality in the Teaching of Caring Professionals
Chris Osmond, PhD

Nurses Striving to Make a Difference: A Grounded Theory Narrative Inquiry
Wendy E. Miller, DNP, RN, CNE

Mrs. D: Exploring Narrative as Transforming Care for Diabetes Management in Primary Practice
Dana E. Brackney, PhD, RN, CDE, BC-ADM

The Power to Uplift the Spirit: Exploration of Narrative Inquiry in Action
Sharon Ann Cumbie, PhD, RN, CS; Wendy E. Miller, DNP, RN, CNE; Chris Osmond, PhD & Dana E. Brackney, PhD, RN, CDE, BC-ADM

Symposium Introduction and Overview
The purpose of this symposium is to demonstrate how narrative methods can provide a transformative structure for the caring professions. The symposium presentations focus on three distinct narrative endeavors: pedagogy, inquiry/research, and practice. The aims of the symposium are to introduce narrative theory and pedagogy, describe the impact of narrative in education, describe implementation of narrative into advanced practice nursing, and to conclude with a group experiential exercise that will highlight approaches possible with narrative pedagogy.

First, Chris Osmond will present his paper, Temporality in the Teaching of Caring Professionals: Currere as Narrative Pedagogy. The author describes a pedagogical approach to narrative inquiry developed through work with interdisciplinary groups of pre-service nurses and other caring professionals. He concludes by suggesting pedagogical dispositions and habits that are useful to nurture self-awareness, increase empathy attitudes, and develop capacities for self-care. Following, Wendy E. Miller, will present her paper, Nurses Striving to Make a Difference: A Grounded Theory-Narrative
Inquiry. Dr. Miller will describe the impact of the integration of narrative into a nursing course and examine how narrative study enhanced students' understanding of caring. She will discuss the grounded theory-narrative inquiry method that was used as a systematic approach for collection and analysis of qualitative data and generation of explanatory theory.

Dana E. Brackney will then present her paper, *Mrs. D: Exploring Narrative as Transforming Care of Diabetes Management in Primary Practice*. Dr. Brackney will discuss how ongoing and frequent health visits with persons living with chronic illness lend themselves to a mutual sharing of narratives over time. Through a case study, she will demonstrate the use of narrative analysis to engage in a reflective caring diabetes practice that is patient-centered. Finally, Sharon A. Cumbie will coordinate a synthesis session of the symposium, in which participants will engage in a narrative inquiry experience. Symposium presenters will guide participants through a narrative reading and reflection on its meaning. The session will conclude with group discussion of how participants envision incorporating narrative into their caring practice.

**Temporality in the Teaching of Caring Professionals: Currere as Narrative Pedagogy**

*Currere* names curriculum as autobiographical, situated, and recursive. It is narrative practice – the telling of oneself into that which is to be learned – and holds that “the structures of school and the academic disciplines, though clearly perceived as distinct and separate from the learner, can be connected to [the learner’s] own biography so he can make use of them without giving himself up to them” (Pinar & Grumet, 1976, p. 129). The narrative organization of life is also a temporal organization: it’s a “re-experiencing of the past” that both “triggers re-consideration of present circumstances” and “looks toward what is not yet the case, what is not yet present” (Pinar, 2012, pp. 44-45). These capacities of curriculum – to articulate one’s story while not subsuming it, to situate oneself temporally in relation to one’s own learning – are echoed in the spaces opened by “narrative medicine” approaches to the preparation of caring professionals (Charon, 2004). “Narratives teach us where we come from and where we are going, allowing us to understand the meaning of our own lives,” while at the same time acknowledging the ways that “each time we make the story of our experience,” we “read a different book from the one [we thought we] had written, because the new reading act takes place at a new temporal stance” (Charon, 2006, pp. 42-43).

In our narrative work with interdisciplinary groups of pre-service nurses and other caring professionals, we have sought to forge a pedagogical approach at the intersection of these two perspectives. The approach nurtures self-awareness as a situated being, whose engagement with caring practice is a reading of autobiographic text with “retentive” and “protentive” elements that emerge and fade dependent upon one’s present temporal stance (Iser, 1978). Our pedagogy deliberately engages external texts as well – memoirs of giving and receiving care, short fiction, and poetry – as structures students may use to articulate themselves within another’s experience while maintaining subjective integrity. In our student reflections, we begin to see patterns that guide our pedagogy: rhythms of recursion into previously established order that enables engagement with unfamiliar and chaotic clinical situations; remembering of formerly-felt confidence that informs present-moment caution; above all, retrenching in the minute-to-minute algorithms of task completion that give structure to reflections on one’s emerging identity as a caring professional. In light of these patterns, we offer the formulation of a “zone of sustainable practice” as the crossing point of these rhythms, and suggest pedagogical dispositions and habits that other teachers might use to nurture student self-awareness, increase empathy attitudes toward patients, and develop capacities for self-care.

**Mrs. D: Exploring Narrative as Transforming Care for Diabetes Management in Primary Practice**

Persons living with chronic illness such as diabetes, arthritis, and asthma may have the opportunity to interface frequently with health care providers in primary care settings. The ongoing and frequent health visits lend themselves to a mutual sharing of narratives over time. The nurse who has studied methods of narrative analysis is equipped with these ways of knowing the self and other to buttress a caring practice. Keeping a person’s disease and life history together promotes patient-centered care (Kleinman, 1988). This case exemplar of a patient-centered practice includes both moments of ease and discomforts as the nurse and patient together develop a plan of care (Askham & Chisholm, 2006). This case illustrates the use of narrative analysis to engage in a reflective caring diabetes practice that is patient-centered. A patient is defined as someone who seeks professional help for their symptoms (Lorber, 1997). The exemplar explores the patient’s, Mrs. D’s, explanatory models of illness (Frank, 1995) and the impact these beliefs had on her treatment plan. The case includes examples of Mrs. D’s restitution, chaos and quest narratives with suggestions for (1) exploring reframing/rewriting stories that inhibit a patient from achieving his/her goals or (2) adapting “usual practice” to conform to a patient’s narrative. The case exemplar explores Mrs. D’s ethic of recollection “Travel plans”, solidarly “The alcohol calls him away” and inspiration “I’ve been blessed. I may not have material things; but, I’ve been blessed” within her quest narrative and the role these voices had in shaping her care. The case concludes exploring Kleinman’s (1988) chronic care method including a mini-ethnography, brief life history, explanatory models/negotiation, and remoralization within the context of the primary care practice, and the
The Power to Uplift the Spirit: Exploration of Narrative Inquiry in Action

Work with narrative has been demonstrated to improve the empathy attitudes of caring professionals toward patients and clients (Clary, 2008), as well as enhance caregivers’ development of behaviors to increase capacity for self-care and resilience to burnout (Kearney, Weininger, Vachon, Harrison, & Mount, 2009). Narrative work also exploits what Turner (1991) describes as literature’s capacity to counteract the “dehumanizing” aspects of contemporary clinical practice - aspects that have been noted as troubling factors in the documented decline in caregivers’ empathy toward patients early in their clinical experience (Hojat et al., 2009). The introduction of narrative into education and practice offers rich opportunities to advance interpretive and communication skills, enhance capacity for empathy, and develop essential self-care dispositions that promote self-renewal.

In this synthesis session of the symposium, participants will engage in a narrative inquiry experience. Our intention is to guide participants through a narrative inquiry process, which will allow them experience a caring moment through the perspective of another. We will begin by reading of a selection from The Heart’s Truth: Essays on the Art of Nursing (Davis, 2009), and will then facilitate participants to engage in group dialogue to reflect upon the narrative reading. We will conclude the group’s discussion with an exploration of how participants envision they could incorporate narrative into their practice.

Symposium: Caring in Nursing as Communicative Action: Applying Strong Theory in Survey Research

Jane F. Sumner, PhD, RN, APRN, BC, Louisiana State University, New Orleans, LA, USA; William P. Fisher, Jr., PhD, University of California, Berkeley, CA, USA

Background. Nurse-patient interactions contextualized relative to Habermas’ (1995) theory of communicative action are each characterized by two perspectives (Sumner, 2001, 2004, 2008). Both nurse and patient have personal perspectives that are intrasubjective and include every aspect of the individual, including emotion and reason. The nurse’s second perspective is professional, involving factual, theoretical, practical, and experiential knowledge, while the illness self of the patient includes the diagnosis, coping mechanisms, and family supports. The professional self of the nurse and the illness self of the patient are influenced by reason and emotion stamps its own imprimatur on the responses of each, both internally and toward the other.

The foundational premise or elemental prototype is identified as the patient and nurse within a bi-directional communicative relationship. Utilizing a probabilistic view (Morse, 1995), the attributes of this relationship were characterized within the boundaries of the interaction, which are the roles nurse and patient assume within a healthcare delivery system.

Survey items were written specific to issues of caring as experienced by the personal and the professional selves of the nurse, and by the personal and illness selves of the patient. For the nurse items, the presentation of the professional self is expected before the presentation of the personal self (i.e., the professional self items will garner more agreeable ratings and calibrate lower on the scale than the personal self items), and that the integration of professional and personal selves will follow (with these items calibrating highest of all). Varying emphases on reason or emotion as contributing factors were also noted in all items.

Of a bank of 185 items that was developed, 44 focused on how nurses’ professional identities are shaped through caring behaviors. Responses were made using a six-category rating scale (Very Strongly Agree to Very Strongly Disagree) and were obtained from 187 nurses in three countries. Institutional Review Board approval of the study design was obtained. Each participant was provided with an information packet containing a letter explaining the study, a consent form to read, sign, have witnessed, and return to the principal investigator. A contact name and telephone number was provided for questions.

Cronbach’s alpha for measures on the Nurses’ Caring Identity subscale was .98. Analysis shows that the Caring Identity items conform to theory, for both the Professional/Personal Self and the Emotion/Cognition categorizations. Rasch measurement and graphical analyses show that the items related to the professional self, such as technical skills, elicited the most agreement, with greater disagreement for items related to the personal self. Those nurses who had high scores reveal an understanding that the personal self is an active participant in caring in nursing bi-directional communication, and he or she utilizes both emotion and cognition within the interaction.

Bi-directional communication between equal human beings enables the totality of each individual to be part of the interactive process. By explaining the levels of moral maturity found in caring, the duty and obligation of nursing is explained. This theory provides both ontological and epistemological insights into caring in nursing.

Caring in Nursing: Toward a Problem-Focused Methodological Pluralism

William P. Fisher, Jr., PhD, University of California, Berkeley, CA, USA; Jane F. Sumner, PhD, RN, APRN, BC, Louisiana State University, New Orleans, LA, USA

Background: Caring in nursing is predicated on understanding the lived experience of the patient and
applying the appropriate knowledge and skills to alleviate suffering. As the crux of clinical practice, caring requires nurse and patient to participate together in a complex communicative relationship. Though the practice of caring in nursing defines the field as a profession, the processes and outcomes of caring in nursing have been difficult to encompass in theory, and difficult to quantify. Recent advances in measurement theory and practice present possibilities for a sequential mixed method approach that guides theory development and integrates qualitative and quantitative data and methods in new ways. Defining and measuring constructs embodying the theory and practice of caring in nursing is essential to the forward progress of the field. Individualized profiles of nurses’ caring behaviors and attitudes could be useful in education, recruitment, retention, and promotion efforts in nursing.

**Objectives:** In this study, Kohlberg’s theory of moral development was applied in the context of a conceptualization of caring in nursing informed by Critical Theory (Habermas, 1995) that foregrounds the role of the nurse as full partner in the provision of care (Sumner, 2004, 2006). Advanced construct modeling (Wilson, 2005) informed a rigorous integration of qualitative and quantitative data and methods. This research aligns theory and evidence in studying caring in nursing by evaluating the power of a construct theory to predict observed data and by rigorously defining additive quantity in measurement (e.g., Dawson, 2002; Stenner & Stone, 2010; Sumner & Fisher, 2008).

**Methods:** Human subjects’ review approval was obtained before this study commenced. Seven major aspects of caring in nursing (Caring Identity, Patient Focus, Professionalism, Partnership with the Patient, Mutuality in Communication, Responsibilities of Care, and State of Nursing Practice) were identified in the qualitative results of a previous study (Sumner, 2006). Qualitative construct theory informed the design and ranking of survey items (184 in total) intended to vary from agreeable to disagreeable. The survey was administered via paper and pencil in three forms to 82 nurses, and via the Internet in one form to 104 nurses.

**Results:** Measurement reliabilities (Cronbach’s alpha) for six of the seven scales range from .91 to .98; the seventh was .82. Model fit was satisfactory for each scale. The data-based calibrations conformed to theoretical expectation (F =2.4, 3 df, p = 0.08 in an ANOVA of the mean calibrations by theoretical category for the Caring Identity scale). Average measures and item hierarchies were invariant across administrative formats. Developmental progressions defined in the scales, and individual nurses’ significant departures from the expected patterns, inform interpretations of the measures qualitatively.

**Conclusions:** This complex and multifaceted theory situates the nurse and patient in discourse with each other within the healthcare delivery system. Articulating different facets of the nurse’s personal and professional self-presentation relative to the patient’s personal self and illness self usefully addresses affective and behavioral issues in caring. This array of tools facilitates bi-directional communication between equal human beings, and shows each to be enriched by finding themselves in each other.

**The Role of Care in Bringing Human and Social Capital to Life in Nursing**

William P. Fisher, Jr., PhD, University of California, Berkeley, CA, USA; Jane F. Sumner, PhD, RN, APRN, BC; Louisiana State University, New Orleans, LA, USA

Situating caring in a “transpersonal framework of conscious intentionality,” Watson (1999, pp. 237, 243-259) notes that postmodern analyses and concepts often fail to move beyond critical evaluations of failed philosophies or methods to new ways of constructing possibilities for healing environments. If, following Watson, nurses are to be able to assume roles as “ontological architects” designing healing spaces; they will need a new science of ontological engineering to support them. Just as it is said that “science is measurement,” so, also, “engineering is metrology,” i.e., the discipline that creates and maintains invariant reference standard units.

Recent research and texts on measuring caring in nursing show, however, that nursing has not yet adapted to a significant degree relevant advances in measurement theory and practice made over the last several decades. Though there are exceptions, technical presentations may benefit from economic arguments that more clearly convey the value of precision measurement.

The metaphor of an engineering domain informing nursing’s ontological architects provides a fertile context for exploring the kind of infrastructure investments in caring human and social capital require if they are to be held more fully accountable for their returns. The central question is how might caring human and social capital in nursing be conceived, midwifed, and nurtured to a fuller economic maturity? These forms of capital function unmanageably in highly inefficient markets because of the common but eliminable difficulties associated with determining and representing value. Better measurement is key to overcoming these difficulties.

Possibilities for ontological engineering in nursing reside in the realization that “The first concern of all dialogical and dialectical inquiry is a care for the unity and sameness of the thing under discussion” (Gadamer, 1991, p. 61; original emphasis). Dialogical and dialectical inquiry into care requires the same careful attention to unity and sameness as that accorded any other object of inquiry. Scientific models and laws similarly posit abstract mathematical ideals as heuristic fictions guiding inquiry. Instruments imperfectly embody each separate phenomenon’s perceptual profile and they do so in measuring units that are, first, experimentally determined to be of a constant size, and, second, expressed in a standardized numeric metric.
These determinations of unit size and their standardization are facilitated by Rasch measurement models, which support Watson's goal of an "ontological architecture" by coordinating and mediating the matching of caring skills with caring challenges. This matching could be more efficiently facilitated in nursing education and practice through the judicious harmonization of an array of well-tuned instruments. Properly situated within a problem-focused methodological pluralism (Dawson, Fischer, & Stein, 2006), care for the unity and sameness of the objects of healing conversations will nurture the smallest seeds of possibility into fruitful trees of realized productivity for nurses and their patients.

Capturing Caring Competencies

Terry L. Eggenberger, PhD, RN, CNE; Kathryn B. Keller, PhD, RN, CNE; Susan K. Chase, EdD, FNP-BC, FNAP; Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA, University of Central Florida, Orlando, FL, USA

If competency can be determined from simulation experiences, it became important to determine if caring behaviors were too illusive to capture, or if they could be measured. The Caring Efficacy Scale-Simulation Student and Faculty versions were adapted from Coates' Caring Efficacy Scale (2009) for use in a single simulation experience. Fifty-seven traditional and accelerated students participated in this research in an adult acute simulation experience with a charge nurse available for support. The patient in this nursing situation experienced a cardiac arrest in the presence of his wife. Student caring efficacy self-ratings and faculty (consisting of a faculty member who was not the clinical instructor and a doctoral student) objective ratings correlated well (r = 0.345, 0.356). Simulations were videotaped, and raters utilized both live and videotaped sessions to complete the faculty versions of the tool, and to determine inter-rater reliability. Students who rated themselves highly in terms of caring efficacy where also rated high by the faculty. The Caring Efficacy Scale-Simulation Student and Faculty Versions were useful in measuring caring in this simulation experience.

Embracing the Difference Caring Makes in Simulation

Jill Winland-Brown, EdD, FNP-BC; Josie Weiss, PhD, FNP-BC, FAANP; Susan Garnett, MSN, FNP-BC; David Newman, PhD, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

New evidence has shown that caring science can be infused into simulated clinical experiences (SCE) and that caring can be evaluated after a scenario. This presentation will demonstrate the development of a simulation program for advanced practice nursing students that is based on caring science. A complex clinical visit scenario used in a family nurse practitioner program using a high fidelity simulator as

Symposium: Caring: Honoring the Past, Co-Creating the Present and Envisioning the Future

Marlaine C. Smith, PhD, RN, AHN-BC, FAAN, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL, USA; Marian C. Turkel, PhD, RN, NEA-BC, FAAN, Einstein Healthcare Network, Philadelphia, PA, USA; Zane Robinson Wolf, PhD, RN, FAAN, La Salle University School of Nursing and Health Sciences, Philadelphia, PA, USA

Descriptions of what caring in nursing really means range from the essence of nursing to an often-repeated phrase spoken by nurses who provide direct patient care every day. Many nurse scholars and clinicians have offered their perspectives on caring, realizing its importance to professional nursing practice. But the significant work of caring scholars began to emerge during the 1970s, laying the foundation for the profession of current conceptualizations and activities and providing the path for emerging possibilities for the future. The purpose of this symposium is to provide an overview of the seminal work of early nursing scholars, to synthesize caring scholarship informing contemporary nursing education, practice, and research, and to open the conversation related to the future of caring conceptualized from the epistemology and ontology of the scholarly works that have preceded it.

The year 2013 marks 35 years from when Dr. Madeline Leininger and Dr. Jean Watson and a group of doctoral students gathered for the first conference to present research and philosophical reflections related to caring and nursing. This group continued to meet every year to reflect, dialogue, and share research and philosophical assumptions about caring. In 1988, the group formalized and became known as the International Association for Human Caring. It is important to acknowledge and re-discover the history of caring. The early work of the caring scholar pioneers and visionaries Delores Gaut, Patricia Larson, Madeline Leininger, Delores Riemen, Simone Roach, Jean Watson, and Paterson and Zderad will be highlighted and their contributions to the ethical, philosophical, and theoretical development of the discipline.
of nursing presented. Reflective questions for future dialogue and scholarly discourse will be posed.

During the late 1980s, caring scholarship continued to emerge, the thinking of some of the pioneers evolved from earlier work, and caring scholarship related to education, practice, and research was developed by other scholars. Ideas related to the advancement of knowledge and caring within nursing, mid-range theories, and qualitative research on caring emerged. The work of current scholars Boykin and Schoenhofer, Nyberg, Ray, Turkel, Smith, Valentine, and Wolf will be presented as seminal to professional nursing practice and to illustrate how caring scholarship informs and guides practice.

The rich history of caring scholarship informed the discipline and transformed practice. Envisioning the future requires reflection and ongoing scholarly discourse. The following philosophical assumptions will be presented. Is caring the unifying focus of the discipline? Will caring become part of the metaparadigm of nursing? What will nursing education, practice, and research grounded in caring look like in 2020? And, will new theories of nursing emerge?

Aesthetic Presentation

Vulnerability as Transformative Potential: A Model for Caritas Social Action
A. Lynne Wagner, EdD, RN, Watson Caring Science Institute, Fitchburg State University, Fitchburg, MA, USA; Sharon Ann Cumbie, PhD, RN, CS, College of Health Sciences, Appalachian State University, Boone, NC, USA; Susan Hagedorn, PhD, RN, PNP, WHNP, FAANP, University of Colorado at Denver Health Sciences, Center Producer & Director, Seedworks Films, Boulder, CO, USA

Vulnerability is a complex multidimensional phenomenon that affects the physical, emotional, social, and spiritual realms of existence. An essential and inescapable aspect of the human condition, vulnerability is a state of openness and susceptibility that challenges and at times overwhelms our sense of being. Vulnerable persons or groups are often victims of far-reaching social and political injustices. However, a caring response to vulnerability creates a transformative opportunity for growth, discovery, and increased resiliency for individuals and groups. Leaving our comfort zone to enter the story, dwelling inside the lived experience of vulnerable persons of diverse backgrounds, we ourselves are changed. We face and confront our own vulnerability through our connected humanity as we listen and grasp the disharmonious timbre of life’s voice. We thus make ourselves increasingly present and responsive to others through a connected understanding that is authentic and healing. Awakening the call to action, the collected stories of vulnerable persons provide a powerful transformative voice that offers a conduit toward the actualization of personal and social change.

Using a heuristic approach, this presentational drama weaves together diverse voices from our gathered stories, photography, art, and music, which integrates the perspectives from three researchers’ work to create an aesthetic-hermeneutic reflection on the meaning of vulnerability. Through this reflective-experiential process of immersion into the stories, we were able to synthesize the various perspectives, creating a multi-media presentation/performance that allows the audience to transcend abstract-theoretical views of vulnerability and enter into the sacred space of lived experience. Innovative approaches to theory building/relating create deeper levels and opportunities for participants’ exploration and understanding of crucial human phenomena. A theoretical model of the transformative potential of vulnerability has subsequently emerged and will be presented in conclusion. A richer understanding of vulnerability enhances caritas intention toward healing processes, facilitating discovery about self and others, and thereby, increasing the efficacy of assisting vulnerable persons and populations survive with new life skills and integration.

Symposium:
The Magic of Innovation in Simulation: Novel Ways to Embrace Caring Science

This symposium illustrates ways that caring science can be transmitted or evaluated across simulation programs in a College of Nursing grounded in a caring philosophy. Graduates from these programs are then able to transition the ways they have grown in their understanding of caring science into varying practice settings.

Unraveling the Mysteries of Simulation in Caring
Kathryn B. Keller, PhD, RN, CNE; Terry L. Eggenberger, PhD, RN, CNE, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

The faculty’s journey began with demystifying the process of how to incorporate caring behaviors in simulated scenarios. The models for building scenarios lacked content that delineated, described and explained the theoretical perspective of caring in nursing. A framework was created for grounding simulation in caring science. The next step was to explore how undergraduate students come to know persons as caring and how caring is expressed using a high-fidelity human simulator in emergent nursing situations. Next, it became crucial to ensure that others could replicate this process if they were going to be replacing clinical experiences with simulated experiences. Fortunately, the faculty teaches a course called “Creative Teaching-Learning Methods in Nursing Education” for graduate nursing students. This forum provides an opportunity for faculty to mentor future nursing educators as they create their own simulation scenarios that infuse caring science into their specialty nursing experiences during a weekend.
workshop. Stories from our graduates that have taken these skills into practice will be shared along with examples of their scenarios. This experience links research, education, and the potential to impact practice from a caring science framework.

**Podium Presentations**

**Tapping the Power of the Hermeneutical Mystery of “Evidence” in Developing Caring Knowledge**
Laurie Abbott, MSN, RN, Florida Atlantic University
Christine E. Lynn College of Nursing, PhD student, Boca Raton, FL, USA, Florida State University, Tallahassee, FL, USA

**Introduction:** Words can often have hidden and mysterious meanings as the effects of history throughout the centuries influence contemporary interpretations of linguistics applicable to research and caring science. Caring is considered by many as the essence of the discipline of nursing. Defining the essence of nursing requires a foundation of evidence generated from philosophical inquiry, scientific research and practice situations. As a result, evidence moves beyond the usually considered product of scientific truth discovered following the process of scientific research. The purpose of this presentation is to extend what is considered credible evidence for developing caring knowledge, illuminating the hermeneutical understanding of the term “evidence” as that which includes much more than empirics in the study of the uniquely human encounters that occur within nursing situations.

**Theoretical Lens:** The theoretical lens for the exploration of the hermeneutical meaning of the word “evidence” includes an understanding of the philosophy of Hans-Georg Gadamer through the eyes of Katie Eriksson. Within the context of caring science, what constitutes evidence is expanded by hermeneutics as one comes to know philosophy, scientific research and the unique experiences that occur in nursing situations. The meaning of “evidence” as viewed through Gadamer’s hermeneutics sheds light on the mystery essential to the development of caring knowledge.

**Application:** The application of the full meaning of what is considered evidence in developing caring knowledge expands the methods employed by researchers in capturing the essence of caring. Valuable data gathered from philosophical insights, qualitative research, and stories are considered evidence in the hermeneutical understanding of the term, and this range of evidence promises movement to embrace the complexity of nursing situations reframing mystery as an ever evolving challenge of coming to know in a meaningful way.

**Implications:** The unfolding of this mystery has the potential for building the body of caring knowledge, expanding the concepts of what is considered credible evidence, and furthering the discipline of nursing in the area of caring research.

**Caring to Lead: A Study of Clinical Nurse Council Leaders in Shared Governance**
Susan R. Allen, PhD(c), RN-BC; Edith J. Morris, PhD, RN, APRN-BC, Cincinnati Children’s Hospital Medical Center and University of Cincinnati, Cincinnati, OH, USA

The Institute of Medicine’s 2010 report states that nurses must become equal partners with physicians and other members of the health care team. More importantly, nurses must become leaders in health care for needed improvements to occur. It is critical to understand how nurses become the leaders they need to be. Sharing the governance of a health care organization may be one way for this to occur. Shared governance models have been implemented in health care organizations throughout the world in the past two decades. These models are based on professional values and principles of autonomy, shared decision making, and engaged participation. Decisions about nursing practice made closest to the point of care by the people caring for the patients are better decisions (IOM, 2004). Moving from a vertical governance structure to a shared leadership organizational model requires significant changes in the culture of an organization, and the behaviors, beliefs, and values of its members. Mutuality in shared governance is clinical staff members and managers engaged in equitable, reciprocal communication to share leadership and decision making.

The purpose of this ethnonursing study was to discover, describe, and systematically analyze the expressions, experiences, and meanings of the lifeways of selected staff nurse council leaders in a shared governance environment within a health care organization as they became leaders and learned to make decisions about their practice and patient care. The aims of this study were: 1) to gain new knowledge from participants about the experience of becoming a formal leader; 2) discover barriers that may exist in the development of caring practices that prepare them to be leaders; and 3) analyze how caring relationships develop to promote leadership. Its overall goal was to better position nurses as leaders in health care. Fourteen key informants and 31 general informants participated in the study.

Data analysis is currently in progress. Preliminary findings from a pilot study illustrate how caring relationships assist staff nurse council leaders to discover leadership within themselves and find their own voice, give voice to other nurses, accept personal and professional accountability for their nursing practice, and advocate for appropriate care for patients and families. Barriers identified were difficulty balancing competing responsibilities, lack of support from peers and managers, and lack of preparation for their leadership role. Caring practices discovered were all levels of nurses sharing common beliefs about the value of nursing practice within the organization; these beliefs were reflected in their practice and in interactions with others. Final study findings will be presented.
The Adaptation of New Registered Nurses
Kathleen S. Ashton, PhD(c), RN, University of North Carolina at Greensboro, Greensboro, NC, USA

Background: New registered nurses (new RNs) report they experience work-related stress, multiple challenges, and negative emotional responses during their first year in practice. Minimally, this represents a compensatory level of adaptation, but it is also very likely that this reflects a compromised level of adaptation. Although the topic of new RNs’ assimilation into professional practice is frequently discussed in the literature, our understanding of the new RNs’ experiences is limited. Nurse researchers’ attention to new RN’s adaptation demonstrates authentic, intra-professional caring for new nurses.

Aims: The aim of this research study was to explore adaptation in new registered nurses.

Methods: A cross-sectional, correlational design was used to explore adaptation in new RNs. With the Roy Adaptation Model as the conceptual framework, personal attributes of new registered nurses and characteristics of their work environment were modeled as independent variables with four measures of adaptation: acute occupational fatigue, chronic occupational fatigue, negative affect, and intent to stay in their current position for two years. The New Registered Nurse Questionnaire (NRNQ) included: (a) a measure for intent to stay in the current position for two years, (b) two subscales of the Occupational Fatigue Exhaustion Recovery (OFER) Scale, and (c) the negative emotional subscale of the Job-related Affective Well-being Scale (JAWS). The NRNQ was mailed to a random sample of 250 new registered nurses in North Carolina with a professional tenure of 52 weeks or less. Data from 88 new RNs were included for analysis.

Results: Participants reported a mean acute occupational fatigue score of 64.88 (SD = 19.69) out of a possible score of zero to 100. The mean score for chronic occupational fatigue was lower at 41.86 (SD = 23.13) with a minimum-maximum of zero to 90. Of the 11 independent variables, only orientation status and perceived adjustment were statistically significant in their relationship with chronic occupational fatigue and negative affect. The mean length of orientation for participants in this study was 12.12 weeks (SD = 6.17 weeks). Participants’ score for the measure on intent to stay in their current nursing position for two years was 3.38 (SD = 1.39) out of a possible score of one (very unlikely) to five (very likely). Nursing education at the baccalaureate level or higher and orientation status were statistically significant in their relationship with intent to stay in the current nursing position for two years.

Conclusions: These findings indicate that new RNs’ responses to the challenges they experience are ineffective and do not support their overall adaptation to the role of registered nurse. This inquiry into new RNs’ experiences provides a unique contribution to nursing science and exhibits care for new RNs. The nursing profession has an opportunity to respond with an unprecedented level of commitment to new nurses and the patients they will care for by a focused research agenda that leads to well planned, evidence-based support and guidance to keep new nurses engaged, enthusiastic, and employed in nursing.

Nursing Situations: Teaching, Learning and Living Caring in Nursing
Charlotte D. Barry, PhD, RN; NCSN; Shirley C. Gordon, PhD, RN, NCSN, Beth King, RN, PhD, PMHCNS-BC, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL, USA

National groups are calling for innovative educational approaches that help illuminate and unify the complex, divergent dimensions that must be studied in order to competently practice nursing. This presentation will demonstrate the use of contextual stories from day-to-day nursing practice to study nursing.

The study of practice stories, called nursing situations, allows the student to uncover the knowledge, skills and practices most relevant to nursing. Nursing situations assists the student to focus on the caring between the nurse and person, family, or group that enhances well-being. Nursing situations draw students in, away from the desk, chart, doorway, or machine with urgency to experience, to touch, to feel, to participate, and to wonder what it like is for the nurse and patient to be together at this moment, at this time, in this complex particularity.

Presenters will share how they integrate nursing situations as a meaningful teaching/learning strategy in graduate and undergraduate coursework. The learning process through which understanding caring as the essence of nursing emerges will be discussed.

Caring Parents: Relations between the Youth Developmental Assets Model and Dosage of Case Management Visits on Parenting Scores in Project MAS
Andrea E. Berndt, PhD; Gail B. Williams, PhD, RN, School of Nursing, University of Texas Health Science Center at San Antonio, San Antonio, TX, USA

Introduction: This presentation will focus on the impact of the Youth Developmental Assets Model and dosage of individual and group case management visits on parenting scores among adolescent mothers in Project MAS (Mothers and Schools). Project MAS objectives focused on helping teen mothers become nurturing parents and promote positive self-empowerment through increased external and internal developmental assets.

Methods: This project is a quasi-experimental study (intervention versus comparison group). Teens in the
Creating Learning Practice Communities to Improve the Patient’s Experience
Andrea E. Berndt, PhD, School of Nursing, University of Texas Health Science Center at San Antonio, San Antonio, TX, USA; Clarice Golightly-Jenkins, PhD, RN, BSN, MSN, CNS, Methodist Health Care System, San Antonio, TX, USA; Mickey L. Parsons, PhD, MHA, RN FAAN, School of Nursing, University of Texas Health Science Center at San Antonio, San Antonio, TX, USA

Introduction: The purpose of this presentation is to describe an innovative educational strategy, an interprofessional quality study group, in a large multi-hospital system to promote nursing leaders’ contribution to quality improvement in patients’ experiences and clinical outcomes and results. Key principles informed the educational change strategy design. They were to create a learning practice community with the domains of engagement, learning, and support, (2) to break down existing silos via interprofessional learning, and (3) to provide a common language and knowledge of quality improvement (QI) design and measurement to meet the Institute of Medicine’s six aims for 21st Century health care systems. Development of interprofessional partnerships was viewed as essential to guide and promote quality improvement goals at each facility with nurse coordinators and their staff.

Methodology: The Dartmouth curriculum text, Value by Design: Developing clinical Microsystems to achieve organizational excellence, was chosen as guiding content for quality improvement. To facilitate interprofessional learning and discussion, William Fawcett Hill’s Learning Through Discussion was utilized to promote learning about the patient’s perceptions of being cared for across the continuum of care. Evaluation was achieved through the use of the Readiness for Interprofessional Learning Scale and an adapted Learning Practice Inventory with additional participant feedback regarding the effectiveness of the program.

Results: Both pre- and post-test scores supported positive attitudes about interprofessional learning and teaching practice communities. Additionally, strong positive relationships were noted between baseline RIPLS scores and all post-test LPI scores. Participant feedback about their experience was extremely positive and supported that the approach facilitated interest, enthusiasm, and intent to collaborate in future initiatives.

Implications: Insights from interviews with patients renewed participants’ commitment to transform health care delivery and reminded them of the passion that led them to collaboration among health care providers to ensure quality care and outcomes. These findings suggest that interprofessional quality study groups can enhance collaboration among health care providers to ensure quality care and outcomes and improve patients’ healthcare experiences.

Reengaging Mature Nurses: The Impact of a Caring-Based Intervention
Mary Bishop, DNP, RN, NEA BC, FACHE, University of West Georgia, School of Nursing, Carrollton, GA, USA

The growth and aging of the population, along with the continued demand for the highest quality of care, will create a surging need for the services of Registered Nurses (RNs) over the coming two decades (Blakeley & Ribeiro, 2008). However, many RNs are approaching retirement age and the nursing profession will face difficulties retaining the existing
acute care workforce. All these factors can result in increased stress as well as decreased retention of mature registered nurses.

This presentation will discuss the findings of a mixed method evaluation research study conducted in in a community hospital in South Florida. The study was designed to determine the impact of a caring-based program on improving the work engagement of mature registered nurses. The theoretical framework for this research study integrated Schaufeli and Bakker’s theory on work engagement with Boykin and Schoenhofer’s (2001) theory of Nurses as Caring: a Model for Transforming Practice.

It was hypothesized in this study that the level of work engagement in mature registered nurses would increase if given the time to step away from their work in order to reflect and focus attention on taking better care of one self, to strengthen and deepen their relationship with their colleagues and to reconnect with the true reason for becoming a nurse: caring for others.

The findings of this study as well as the caring interventions that were utilized will be presented. A structured three-day offsite program retreat was conducted with the purpose of creating a supportive environment using appreciative inquiry for registered nurses to reflect, share stories, and dialogue about the true meaning of caring. In this study, time was provided away from the acute-care setting to reconnect with the reasons for being a nurse, to focus on self-care, time to hear from patients as to what really matters, and an opportunity for nurses to form bonds with colleagues as well as nursing leaders.

The results of this study suggest that leadership strategies aimed at improving work engagement using caring theories have significant positive impact. The results provide initial support for the use of caring theory driven strategies to attend to issues that need to be addressed in our current nursing work environments.

Caring Connections in Doctoral Education: Embracing the Magic Along the Way

Cynthia Brown, DNS, RN, AHN-BC, University of West Georgia, Carrollton, GA, USA; Priscilla Dunson Bartolone, DNS, RN, College of Nursing, South University, Royal Palm Beach, FL, USA; Judith Drumm, DNS, RN, CPN Palm Beach Atlantic University, West Palm Beach, FL, USA; Debra Hain, PhD, APRN, ANP, GNP-BC, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA; Laureen M. Fleck, PhD, FNP-BC, CDE, Family Medicine of Boca Raton; Boca Raton, FL, USA; Andy Rooney (1919-2011)

“I’ve learned that everyone wants to live on top of the mountain, but all the happiness and growth occurs while you’re climbing it.” Andy Rooney (1919-2011)

The presentation will discuss the findings of a mixed method evaluation research study conducted in a community hospital in South Florida. The study was designed to determine the impact of a caring-based program on improving the work engagement of mature registered nurses. The theoretical framework for this research study integrated Schaufeli and Bakker’s theory on work engagement with Boykin and Schoenhofer’s (2001) theory of Nurses as Caring: a Model for Transforming Practice.

It was hypothesized in this study that the level of work engagement in mature registered nurses would increase if given the time to step away from their work in order to reflect and focus attention on taking better care of one self, to strengthen and deepen their relationship with their colleagues and to reconnect with the true reason for becoming a nurse: caring for others.

The findings of this study as well as the caring interventions that were utilized will be presented. A structured three-day offsite program retreat was conducted with the purpose of creating a supportive environment using appreciative inquiry for registered nurses to reflect, share stories, and dialogue about the true meaning of caring. In this study, time was provided away from the acute-care setting to reconnect with the reasons for being a nurse, to focus on self-care, a time to hear from patients as to what really matters, and an opportunity for nurses to form bonds with colleagues as well as nursing leaders.

The results of this study suggest that leadership strategies aimed at improving work engagement using caring theories have significant positive impact. The results provide initial support for the use of caring theory driven strategies to attend to issues that need to be addressed in our current nursing work environments.

The 34th International Association for Human Caring Conference

Georgann V. Weissman DNP, ARNP, CNE, Capella University, West Palm Beach, FL, USA; Marilyn A. Ray, RN, PhD, CTN-A, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

The journey of doctoral education is a life changing commitment. As with any commitment, there are challenges to be met, goals to be actualized and achievements to be recognized along the way. In 2003, nine nurses embarked on a journey of a caring based doctoral program at Florida Atlantic University, The Christine E. Lynn College of Nursing in South Florida.

As we started our climb in 2003, we had different backgrounds, life experiences, and life challenges. In this presentation, the doctoral cohort and their primary mentor who has helped to keep the circle of caring alive following graduation will share the journey within a caring-based doctoral program of study at the college of nursing. The unique caring-based curriculum is dedicated to nursing as caring: expanding the science, studying the meaning, practicing the art, weaving caring science and the art of caring into all courses and living it day-to-day. We will describe our circle of caring; how we were supported by caring faculty mentors along the way, how we supported each other through the peaks and valleys of our climb together and celebrated each milestone both before and after graduation. The mentor role will be illuminated by one of our doctoral professors. It is hoped our experience will help nurses as they embark on their doctoral journey.

We have kept in touch through the years by gathering for dinners, through email, social media, and attending conferences. As we continue our journey, our friendship and scholarship grows along the way. At this 10-year anniversary of the beginning of our doctoral journey, we celebrate the magic of our caring connection. We share our stories about the lives we have touched and the organizations we have transformed as we continue to follow our calling, through education, practice, research, and as caring nursing leaders. We have taken diverse roles within the local, state, national, and international communities. We continue to strengthen our cohesiveness through a shared value of making our approach to patient care holistic and safe, through our dedication in education, seeking excellence as primary care providers, in leadership roles, and in research.
Creating and Sustaining Peace Within for the Journey of Self Care for Nurses: An Experiential Podium Presentation

Cynthia J. Brown, DNS, RN, AHN-BC; Mary Bishop, DNP, RN, NEA-BC, FACHE; Bonnie B. Bar, MS, RN, AHN-BC, University of West Georgia, School of Nursing, Carrollton, GA, USA

“Our capacity to make peace with another person and the world, depends very much on our capacity to make peace with ourselves.” Thich Nhat Hanh

Coming to know self is the gateway to peace, health, and happiness. A solid foundation, beginning with listening as a means to come to know self, assists to build strength and resilience to cope with any situation that an individual may encounter in life. As nurses are engaged in increasingly complex healthcare settings, maintaining peace within is a vital component of self-care, imperative for the work environment and essential for patient care. As a component of caring science, peace within self or an inner calmness may be created and maintained by caring for self at a deep level, committing to an inner journey, and by dedication to maintaining a practice of self care.

Suggestions for creating and sustaining peace within self using the model “Listen, Envision and Take Action” (LET or allow) will be explored as a guide to support and maintain an inner journey to enhance self-care and nursing practice. This model of self-care was inspired by the action research design of Look, Think, and Act (Stringer & Genat, 2004). Commitment to self care, beginning with the inner journey, can be achieved by finding what works for the individual, engaging a system of support and discovering approaches to integrate self-care in the work setting. A healing work environment may support the commitment of self-care during a long workday.

This presentation will discuss ways to support the magic of the inner journey and participants will experience the LET process, allowing inspiration and creativity to emerge. This simple act of the power of caring, beginning with self-knowledge gained from the inner journey, can allow transformation of self and all of those around us, bringing peace to self and out to the world.

Transcultural Caring: Nursing Faculty and Students Immersed in International Clinical Experiences and the Effects on Compassion, Cultural Competence, and Relationship-Building

Sandra. J. Cadena, PhD, APRN, Walden University, Universidad Autonoma de Bucaramanga Universidad el Bosque, Colombia

Transcultural nursing (Leininger) and Transpersonal caring (Watson) share aspects of relationships on nursing students and faculty in their work together and in unison with their patients. The author is the founder of a Global Health nursing program, providing clinical opportunities that have immersed undergraduate nursing students in clinical and cultural experiences in Panama, Central America over the past eight years. Students and faculty from the United States work side by side with students and faculty from three university schools of nursing in this Central American country. Aspects of the Panamanian nursing philosophy embraces prevention and promotion of health, translating into a heightened awareness of compassion and caring in students and faculty from the United States. The effectiveness of these interventions in building international, caring relationships has the potential to alter student and faculty perceptions of health care delivery upon their return home.

Multiple aspects of the Global Health program will be presented, including two studies focused on student cultural competency, phenomenology of international clinical immersion experiences, awareness and enhancement of compassion, development of a global education relationship-building model, and lessons learned.

Creation of a Caring Science Elective for Freshmen and Sophomore Students

Gayle L. Casterline, PhD, RN, CNE, Queens University of Charlotte, NC, USA

In the spring of 2012, all faculty at Queens University were invited to submit proposals for Exploration Seminars – 1 credit hour courses focused on a discipline-specific question that could be explored through experiential (“hands on”) learning. These seminars were to engage faculty-student mentoring. Courses were to present students with a complex, realistic problem that could be explored through experiential learning. Course design was to encourage students to work independently in small groups, and to teach students problem-solving techniques and disciplinary content in order to encourage them to begin thinking in a new way. Five Exploration Seminars were selected by the Quality Enhancement Plan (QEP) Committee and opened to all undergraduate students but designed especially for freshmen and sophomores. Faculty were awarded a $1,000 stipend for course development and received 1 credit load hour.

This presentation will discuss the development of a course in caring science entitled, Acts of Random Kindness: Creating an Intentional Caring Lifestyle. A blue-print for a caring-based lifestyle was explored. The course description was:

Caring is for everyone; trusting relationships build strong families, quality friendships, powerful workplace teams, community partnerships, and global peace. Caring self-care practices improve physical and emotional health and personal growth. This course will employ imagination, intuition, aesthetics, ethics, spirituality, empirics, and technical skills to discover a
kinder way to live in the world. Students will experience new opportunities to care for self and others through authentic listening, assertive communication, guided imagery, relaxation, meditation, aromatherapy, energy work, music, art, movement, massage, and journaling.

The central issue to be explored was the need to create an ethical and civil society through a loving, caring approach to self and others. As a faculty associate for Watson Caring Science Institute, the author is an experienced facilitator for experiential activities in human caring science. Students worked independently in small groups, gaining opportunities to care for self and others through authentic listening, assertive communication, guided imagery, relaxation, meditation, aromatherapy, energy work, music, art, movement, massage, and journaling. Students explored personal awareness and growth, stress management, and strategies for improving collaboration and communication with others. A reflective caring science model that embraces the best of both science and art encouraged the student to honor values, expanded consciousness, and positive intentionality when building personal and professional relationships.

A Native American Transcultural Caring Immersion Experience for Nursing Students
Rose M. Cirilo, RN, BSN-PhD student; John Lowe, RN, PhD, FAAN, Florida Atlantic University Christine E. Lynn College of Nursing, Davie, FL, USA

The Florida Atlantic University, Christine E. Lynn College of Nursing has an agreement with two Native American tribes in Oklahoma: the Cherokee Nation and the United Keetoowah Band of Cherokee Indians. This agreement allows nursing students to participate in a unique transcultural caring immersion learning experience. This experience addresses key course objectives related to learning about health disparities, cultural competence, diversity, and community-based health promotion and disease prevention. Because the Florida Atlantic University Christine E. Lynn College of Nursing curriculum is guided by the Nursing as Caring Theory (Boykin & Schoenhofer, 2001), much can be learned about what students have learned from this unique transcultural caring immersion learning experience within the two tribal settings.

A qualitative approach was utilized for this study by using a focus group conducted in the Talking Circle format. The focus groups were facilitated by a consultant who is a Native American leader and cultural expert. The Talking Circle is a format generally used by Native Americans where individuals come together and each person is given the opportunity to share experiences concerning a topic of interest (Simpson, 2000). General questions were asked to elicit descriptions of the students’ experiences while immersed within the two tribal settings in Oklahoma. The three objectives for the study included: 1) To understand the learning that occurred with the students during their transcultural caring immersion experience within the two tribal settings; 2) To learn what facilitated the students’ learning experiences before, during and after their transcultural caring immersion experience; and 3) To gain information concerning the similarities and differences between the values inherent in the two Native American tribal cultures and those guiding the Nursing as Caring Theory. The focus group Talking Circle sessions were audio-taped recorded to allow for transcription for data analysis. After all transcripts were completed, the data were analyzed using consensus qualitative research (CQR) methods (Hill et al., 2005). CQR involves categorizing data into accurate themes via research team deliberations and external auditing. Core ideas within the themes were abstracted that illustrated aspects of the chosen themes.

Caring for the Nurse in the Hospital Environment
Elizabeth Clerico, RN, MSN, CCRN; Tanya Lott, MSN, RN-BC; Raquel “Kelly” Walker, MSN, RNC-MNN; Erin Kosak, BSN, RN, Bon Secours St. Francis Hospital, Charleston, SC, USA

Nurses at Bon Secours St. Francis (BSSF) hospital adopted Jean Watson’s Theory of Caring as their foundational theory of nursing practice. The members of the BSSF Nursing Research Council (NRC) realized that caring is not a self-renewing resource and wanted to investigate nurses’ perceptions of the hospital environment as caring and the degree to which nurses felt cared for within that environment. The Caring Factor Scale© (Nelson, Watson, & INOVA Healthcare) was modified from reflecting patients’ perceptions of being cared for by providers to nurses’ perception of feeling cared for within the hospital work environment. The BSSF Caring Work Environment Survey consists of 12 questions that measure four domains: physical needs, spiritual needs, intellectual stimulation, and authentic relationships. Responses are based on a 7-point scale, from Strongly Disagree (1) to Strongly Agree (7). The NRC piloted the survey in one unit. Content validity of the refined instrument was established through expert review. Results indicated that the survey is reliable, valid, and responsive.

The hospital’s Institutional review board reviewed the project and waived approval, identifying it as an exempt study. The survey has been administered electronically to all RNs annually since 2008 and has been expanded to include RNs employed at two other hospitals within the healthcare system. Participation is voluntary and confidential. Consent is obtained. The original 12-question survey does not change. Participants are also asked demographic questions that have changed slightly from year to year, relating to, for example, age, gender, number of years in nursing, the primary area of practice, the shift most commonly worked, and caring initiatives offered by the hospital that the nurse has participated in. These initiatives include voluntary participation.
in hospital celebrations, nursing retreats, hospital exercise programs, non-required education opportunities, caring conference, shared governance, or use of meditation gardens on the campus, among others. An open-ended question on the survey provides opportunity for comments.

For the first two years the survey was administered, Factor Analysis using principal component analysis produced a single factor indicating that the four domains were highly correlated. Cronbach’s alpha (0.935 the first year & 0.941 the second year) indicated reliable internal consistency for the 12 items. The overall mean caring score is calculated annually and item analysis is completed to provide comparisons of the domains being measured as well as comparison of responses among different demographics including, for example, areas of practice, shifts worked and caring initiatives that the nurse participated in.

Overall, the nurses feel cared for within the work environment. However, there is significant variation in perception of caring among units within the hospital. Consistently, questions relating to spiritual needs and intellectual stimulation score highest and questions relating to physical needs score lowest. The goal is to utilize the survey results to evaluate factors that contribute to the scores and then implement initiatives that affect the nurses’ perception of feeling cared for within the hospital environment. It is part of the hospital’s ongoing efforts to actualize the Theory of Caring in the work environment and improve patient outcomes.

Nurse as Artist in Artistic Caring
Shirley Conrad-Eckes, BSN, RN, CCRN, Christine E. Lynn College of Nursing. Florida Atlantic University, Boca Raton, FL, USA

Introduction: The Mystery: Ray and Turkel have indicated health care has undergone a “corporatization of a human enterprise” resulting in a nursing crisis. Nursing, inherently humanistic, is being influenced by elements that have not traditionally been considered caring. Contemplating the consequence of imbalance within the holography of a health care bureaucracy, and its effects on inspiring artistic caring is the aim of this paper. The Theory of Bureaucratic Caring by Ray provides a vision for strategies aimed at creating an environment in which artistry of caring and nurse as artist can flourish. The Bureaucratic Caring theoretical framework provides structure to transform systems that support the idea of differential caring throughout an organization with nursing as one component of a holon.

Theoretical Lens: The Magic: It is not unusual to see the ideas of art and caring combined in the literature. In fact caring is often described as an art, yet the idea of nurse as artist is not fully appreciated. Using Leo Tolstoy’s reflections in What is Art, a connection between caring and artistry, and nurse and artist will be drawn, resulting in the idea of artistry in caring. The purpose of this presentation is to reveal that both art and caring are necessary to human life and a means of connection between human beings. However, it is artistry in caring that profoundly constructs this connection for nurses. Ray’s Theory of Bureaucratic Caring will provide the lens for understanding nursing in systems while Tolstoy’s philosophical reflections on art enrich the understanding of caring as artistry.

Application: The Miracle: A nurse’s caring expressions when viewed from the perspective of artist will lead to considerations of how best to sustain this way of being while appreciating the challenges inherent in expressing artistic caring in today’s healthcare environment. Doing so encourages the evolution of self as a caring person and encourages coming to know other(s) as caring person, and eventually bureaucracy as caring.

Implication: Embracing the Difference: Economic challenges and ongoing regulatory changes are creating practice environments that obstruct a carrying tradition, often resulting in disillusionment and an unmet desire to care uniquely. However, nurses live, work, and care in wide-ranging and diverse bureaucracies. Creating mutual relationships within complex bureaucracies that are pressed by obstructive underpinning (political, economic, legal, and technological forces) is imperative if artistic care by nurse is to remain a recognized and valued part of the discipline.

Confessions of a Caring Convert: How My Faculty Led Me Back to Myself
Katharine C. Cook, PhD, RN, CNE, Notre Dame of Maryland University, School of Nursing, Baltimore, MD, USA

At Notre Dame of Maryland University, we are experiencing a renaissance in nursing curriculum based on the caring science paradigm. Rarely do nurse educators have an opportunity to build a nursing curriculum from the ground up. Such an opportunity presented itself when Notre Dame approved an entry level BSN program in its Women’s College. Accelerated nursing programs at Notre Dame have been offered in the College of Adult Studies (RN to BSN) and in the College of Graduate Studies (MSN) for many years. Although both of these programs are student-centered, built on collaborative learning, and different ways of knowing including aesthetics, the faculty want to go to the next level and are designing a caring science curriculum for the entry level program, which will also extend to the BSN completion and graduate programs. The first entry-level students began studies as pre-nursing students in fall 2011. The first nursing majors will begin in fall 2013. Faculty and staff are already involved in the academic lives of the pre-nursing students, teaching in the freshmen IDS course, advising and facilitating caring circles.

As I have evolved over the past two years, watching and participating with faculty in some of the discussions, I found myself again. This is really what I am all about and Notre
Sacred Acts and Human Needs: Foundations for a Caring Science Curriculum
Bethany Correlli, MSN, RN, Notre Dame of Maryland University, School of Nursing, Baltimore, MD, USA

The experience of creating a new nursing program from the ground up is not one that presents itself often. In fact, it is usually termed a “once in a lifetime” opportunity. At Notre Dame, we have had the privilege of creating a new and unique caring science curriculum for entry-level nursing students. Every interaction, every meeting, and every decision – each has been thoughtfully planned and carried forth with the intention of offering possibilities for transformation on the journey of becoming nurses.

In particular, the first nursing course offered to junior-level nursing students is Foundations of a Caring Profession. This course focuses on basic technological caring of persons and includes developing a caring presence during routine bathing and hygiene, linen changes, standard precautions, and safety procedures. Drawing from Hills and Watson’s (2011) work in caring science curriculum development, and consistent with our worldview, we value each nurse-patient encounter and patient moment as an opportunity to provide sacred acts of human care. In viewing basic needs through this lens, we give reverence to every individual and esteem human dignity. During this presentation, we will explore ways in which elements of Dr. Watson’s Ten Caritas Processes (2011) have been woven throughout this course to allow our students’ hearts and minds to experience authentic human caring—touching the mind, body, and spirit of another.

Compassion in Nursing Students
Holly Diesel, PhD, RN; Donna Taliaferro, PhD, RN, Goldfarb School of Nursing at Barnes-Jewish College, Saint Louis, MO, USA

Background: Compassion fatigue was first identified in the early 1990s with emergency room nurses and is now seen in all areas of nursing. Nursing students experience cumulative stress during educational programs which can inhibit effective caring. Creating a culture of caring may not be present as theoretical and practical information needed in programs of nursing is taught.

Purpose: The quasi-experimental study examines components within nursing that are critical to becoming a caring nurse. The study will evaluate nursing students from two schools; the US and Finland, to determine changes in levels of compassion during their nursing program.

Methods: Students from two colleges of nursing were enrolled in a study to evaluate compassion fatigue, anxiety, satisfaction with life and empathy. The students were recruited in their respective cohort groups and completed a series of surveys (ProQol, Jefferson Scale of Empathy, Diener’s Satisfaction with Life Scale, Spielberger’s State Trait Anxiety Inventory, demographic questionnaire).

Results: Univariate summaries will describe demographic and survey data. Background variables of interest will be assessed for independence of country. A post-hoc power analysis will be done at the end of the study as all students enrolled in their first semester of study will be asked to participate. (First round results will be presented).

Implications: Understanding the effect on education on compassion in nursing students may lead to changes in education, assessment and early intervention to ensure development and retention of caring behaviors.
Metaphors of Contemporary Caring Concepts
Susan Driscoll, MPH, MSN, ANP-BC, WHCNP-BC, Kathi Voege Harvey, MSN, FNP-BC; Alina Miracle, MSN, FNP-BC, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

Introduction. Contemporary caring literature has sought to frame common concepts of caring in the discipline of nursing. Reflection on these emerging and unifying constructs of nursing as caring conjures various artistic representations. This paper offers three aesthetic metaphors to clarify the meaning of contemporary caring constructs; a stream, jazz, and a merry-go-round.

Theoretical Lens. Newman, Smith, Dexheimer Pharris, and Jones (2008) and Cowling, Smith, and Watson (2008) argue for a unification of common concepts of caring and their dissolving boundaries within the discipline of nursing. Common themes arise in these two sentinel works and are best described by Cowling, et al. (2008) as a “unitary caring science praxis” that encapsulates the following fundamental competencies: wholeness (no boundaries), consciousness (expanding, open, continuous, transcendent of time and space), caring (process through which wholeness of person is addressed), pattern (how consciousness expresses itself, intuition), transformation (changing) and transcendence (aesthetic knowing through mutual process to a new reality), relationship (between nurse and other), and meaning (deeper meaning leading to expanded consciousness).

Results. A stream, jazz, and a merry-go-round are offered as metaphoric representations of “unitary caring science praxis” to clarify its meaning and enhance its understanding. The banks of the stream guide the waters of the discipline of nursing, which twist, turn, ebb, and flow as they are rejuvenated or hindered in their journey. The stream nourishes the land it flows through (the nursed) and becomes a stronger, larger body of water as it forges into the sea. Jazz musicians form a “relationship” of “caring” to improvise the “wholeness” of music in the here and now through a “mutual process” of “consciousness” and “patterning”. Finally, the patient is the center of the merry-go-round and their “patterning” radiates, as the nurse moves along the outside rail and becomes “present” with patient’s “pattern.”

Discussion. A deeper understanding and knowing is often best accomplished through artistic expression. Therefore, contemplation of “unitary caring science praxis” through the three aesthetic metaphors of a stream, jazz, and merry-go-round, will help to clarify its meaning within the discipline of nursing.

Nursing Presence: Process, Openness, and Transformation Within the Context of Swanson’s Caring Theory
Susan Driscoll, MPH, MSN, ANP-BC, WHCNP-BC, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

Introduction. Presence in nursing practice goes beyond physical presence. Many prominent nursing theorists, including King, Orem, Peplau, Parse, and Roy, have written that a nurse’s presence is required to provide a healing environment and although there are differences in uses and meanings of the concept, consistent themes emerge. This paper proposes that common attributes of nursing presence in the caring literature include process, openness, and transformation. Furthermore, these attributes can be explained within the paradigm of Swanson’s caring theory.

Theoretical Lens. Swanson describes caring as five processes; knowing, being with, doing for, enabling, and maintaining belief. These processes have been observed in nursing practice and shown to improve patient outcomes, which supports its use in nursing practice and as a tool to clarify and explain the attributes of nursing presence.

Results. Process. Newman, Smith, Pharris, and Jones explain nursing presence as a “mutual process” of “unfolding pattern” enhanced by a nurse’s authentic presence, Parse as unfolding in the “emerging now,” and Finfgeld-Connett point to the effect of presence going into the future. This aligns with Swanson’s five essential processes of caring, where knowing is an “ongoing cue-seeking assessment of the experience of the one cared for,” being with “conveys ongoing availability whether joyful or painful,” and enabling is a process which “facilitates the one’s capacity to grow and heal.” The physical measure of presence may happen within a distinct event, but nursing presence is a process that is constantly evolving and transforming. Openness. Nurses cannot pre-judge or be rigid within their own world view to participate openly in presence with another. Boykin and Schoenhofer refer to it as, “letting go…so that we may see and be in new ways and understand the others call for nursing.” Newman sees it as “clearing the field” for the patient’s way of knowing and Parse says it is “bearing witness in solemn regard for the other” or opening up to what Gadamer calls the prejudices of self and other. According to Swanson, presence cannot occur unless the nurse is open to assessing the experience of the one cared for and nurse and patient become engaged with one another, allowing the nurse to “know” the other as person. She also describes “being with” as “being emotionally present to the other” and “becoming emotionally open to the other’s reality.” Care that is “doing for” is comforting, anticipatory, maintains dignity of the other, and facilitates the patient’s openness in other. This allows “maintaining belief and offers realistic optimism as nurse(d) go the whole distance with the other person.” Openness is at their core. Transformation.
The 34th International Association for Human Caring Conference

Gadamer, Newman, et al., Parse, and others refer to the transformative nature of the nurse/patient relationship involving presence and Swanson's "enabling" facilitates transformation. If presence is fully realized within the nurse/patient relationship, then both the patient and nurse will be transformed forever into something new from the experience.

Discussion. Nursing presence is not only physical presence, but a process between nurse and nursed that is open and transformative. These tenants are explicit in Swanson’s caring processes. To be present in nursing means both nurse and nursed are open to the process of transformation inherent in a relationship grounded in Swanson’s caring theory, in which both are permanently changed by the experience.

The Student’s Experience of Learning Caring
Judith Drumm, DNS, RN, CPN, Palm Beach Atlantic University, West Palm Beach, FL, USA

Caring has been identified as an essential value for baccalaureate nursing education across all programs of study. The purpose of this phenomenological research study was to investigate the lived experience of students learning caring in a college of nursing grounded in a caring philosophy. This study was guided by the caring theories of Boykin and Schoenhofer (2001), Roach (2002) and the philosopher Mayeroff (1971). The researcher interviewed seven senior baccalaureate student nurses attending a public university. The research questions explored the students’ experiences of learning caring in a nursing program grounded in a caring philosophy. One student shared this thought with the researcher: “I knew who I was and I knew I could care about people, but I didn’t know how to use caring in nursing. The educational process helped me to transfer caring to nursing.” Transcripts of the audiotaped interviews were analyzed using Colaizzi’s seven-step methodology. Two major themes and six sub-themes related to learning caring emerged from the research. The two major themes identified were: Innate Knowing of Self as Caring and Caring in the Curriculum. The first major theme of Innate Knowing of Self as Caring is supported by the sub-themes: Being present for the patient, Being open to reshape the patient’s experience, and Enhanced capacity to care. The second major theme of Caring in the Curriculum is supported by the sub-themes: Clinical experiences are valuable to learning, Doing little things to express caring, and Learning activities facilitated understanding caring. Implications for education, research, theory and practice are presented.

The Experience of Unpaid Caregivers at Diagnostic Disclosure of Mild Dementia
Dorothy J. Dunn, PhD, RN, APN-C, FNP-BC, AHN-BC, Northern Arizona University, Flagstaff, AZ, USA

The purpose of this paper is to describe the experiences of unpaid caregivers of persons with mild cognitive impairment and mild Alzheimer's disease (AD) at the time of diagnostic disclosure. A descriptive phenomenological research study design will elucidate the nature of being human in the experience that held personal meaning while caring compassionately for another with AD. The Compassion Energy Theory (CET) formed the theoretical framework basis for this study.

AD is the most common form of dementia among older people and is the sixth leading cause of death in the United States. Unfortunately, the cause of AD remains unknown and screening for memory difficulties occurs long beyond the appearance of the initial symptoms. According to Alzheimer’s Association Disease International (2010) there are 35.6 million people with AD worldwide and this number is expected to increase to 100 million by 2050. In the United States, one in eight people aged 65 and older have AD and approximately 11 to 16 million Americans will have the disease by 2025. The number of family members and friends who will be providing unpaid care to people with dementia is expected to rise. Currently, 14.9 million caregivers provide 17 billion hours of unpaid care, valued at $202.6 billion.

AD is a type of dementia that causes problems with memory, thinking, and behavior. Symptoms usually develop overtime, characterized by subtle patterning that is changing continuously, becoming severe enough to interfere with daily tasks of living and being. Once the disease begins to affect daily life, then the unpaid caregiver enters into the career of caregiver while experiencing a manifestation of patterns within self, care-recipient, and environment. The increase in number of individuals with AD will take an exceptionally high toll on those who care for them, such as a rhythmic pattern manifestation that may be characterized as disharmonious health, employment, income, and financial security.

Caring in Nursing: Toward a Problem-Focused Methodological Pluralism
William P. Fisher, Jr., PhD, University of California, Berkeley, CA, USA; Jane F. Sumner, PhD, RN, APRN, BC, Louisiana State University, New Orleans, LA, USA

Background: Caring in nursing is predicated on understanding the lived experience of the patient and applying the appropriate knowledge and skills to alleviate suffering. As the crux of clinical practice, caring requires nurse and patient to participate together in a complex communicative relationship. Though the practice of caring in nursing defines the field as a profession, the processes and
outcomes of caring in nursing have been difficult to encompass in theory, and difficult to quantify. Recent advances in measurement theory and practice present possibilities for a sequential mixed method approach that guides theory development and integrates qualitative and quantitative data and methods in new ways. Defining and measuring constructs embodying the theory and practice of caring in nursing are essential to the forward progress of the field. Individualized profiles of nurses’ caring behaviors and attitudes could be useful in education, recruitment, retention, and promotion efforts in nursing.

**Objectives:** In this study, Kohlberg’s theory of moral development was applied in the context of a conceptualization of caring in nursing informed by Critical Theory (Habermas, 1995) that foregrounds the role of the nurse as full partner in the provision of care (Sumner, 2004, 2006). Advanced construct modeling (Wilson, 2005) informed a rigorous integration of qualitative and quantitative data and methods. This research aligns theory and evidence in studying caring in nursing by evaluating the power of a construct theory to predict observed data and by rigorously defining additive quantity in measurement (e.g., Dawson, 2002; Stenner & Stone, 2010; Sumner & Fisher, 2008).

**Methods:** Human subject review approval was obtained before this study commenced. Seven major aspects of caring in nursing (Caring Identity, Patient Focus, Professionalism, Partnership with the Patient, Mutuality in Communication, Responsibilities of Care, and State of Nursing Practice) were identified in the qualitative results of a previous study (Sumner, 2006). Qualitative construct theory informed the design and ranking of survey items (184 in total) intended to vary from agreeable to disagreeable. The survey was administered via paper and pencil in three forms to 82 nurses, and via the Internet in one form to 104 nurses.

**Results:** Measurement reliabilities (Cronbach’s alpha) for six of the seven scales range from .91 to .98; the seventh was .82. Model fit was satisfactory for each scale. The data-based calibrations conformed to theoretical expectation ($F = 2.4, 3\ \text{df}, \ p = 0.08$ in an ANOVA of the mean calibrations by theoretical category for the Caring Identity scale). Average measures and item hierarchies were invariant across administrative formats. Developmental progressions defined in the scales, and individual nurses’ significant departures from the expected patterns, qualitatively inform interpretations of the measures.

**Conclusions:** This complex and multifaceted theory situates the nurse and patient in discourse with each other within the healthcare delivery system. Articulating different facets of the nurse’s personal and professional self-presentation relative to the patient’s personal self and illness self usefully addresses affective and behavioral issues in caring. This array of tools facilitates bi-directional communication between equal human beings, and shows each to be enriched by finding themselves in each other.
appreciation for reflexivity and the importance of understanding as a researcher how one is situated in context. Faculty who model caring in research practicum experiences can inspire doctoral students to appreciate their own growth as a caring scholar.

Embodied Being: A Model of Nurse Caring for Individuals Who Have Undergone Organ Transplantation
Valarie S. Grumme, MSN, RN, CCRN, PhD student, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

An extensive review of the literature on transplantation reveals a wide range of patient experiences and perceptions. Individuals may experience a psychological rollercoaster of emotions throughout the transplantation process, beginning with “the wait,” as they ponder an anonymous death or willingness of a compatible loved one to provide a suitable organ. After the transplant is received, the recipient may experience another turbulent period of emotional and psychic readjustment, with the ultimate goal of organ integration into image of self and wholeness. This presentation describes Embodied Being, a model of caring focused on nurturing individuals experiencing organ transplantation. The Model is grounded in caring in nursing and the ethics of organ donation and draws upon the concepts of “safeguarding being,” “the lived body,” and transcendence. The model inspires the nurse to celebrate a unique way of being that supports the individual who has received organ transplantation on his/her journey through the experiences of anticipation, remembrance, awareness of interconnectedness, hope, healing, and transcendence. These themes ground caring in nursing practice to support the transplant recipient as they grow in personhood and come to know themselves as one and whole.

Managing Delirium in Acute Care: The Mystery Can Be Solved through Caring
Candice Hickman, MSN, RN; Meg Scheaffel, BSN, RN, MBA-MHA; Taren Ruggiero, MSN, RN; Adrienne Wolfson, MSN, RN, CCRN-CSC, Holy Cross Hospital, Fort Lauderdale, FL, USA

Delirium is a common occurrence among hospitalized older adults and is associated with significant morbidity and mortality. Delirium can escalate to the point of agitation and acting out, which then poses a safety risk to both nurses and patients. In an effort to protect their patients, nurses sometimes resort to the use of restraints and sedatives, which can cause further agitation, and possibly cause additional complications. An opportunity exists to utilize alternative measures which incorporate caring behaviors to help prevent injury, such as falls, and foster dignity and independence to patients experiencing acute symptoms related to delirium.

At Holy Cross Hospital in Ft. Lauderdale, Florida, an innovative program was created based on the Hospital Elder Life Program (HELP) curriculum. Volunteers selected to participate in the program are educated through simulated patient situations where caring behaviors are modeled. The volunteers then are taught to utilize reminiscence boxes, photography books, music, or simple activities such as drawing or games during time they spend with patients. These initiatives allow authentic presence to occur, and at the same time, the volunteers come to know the patients as person. The result is a decrease in confusion and agitation, as the time spent with a caring volunteer gives the patient an opportunity to express what matters most to them. Referrals are made to a Clinical Practice Specialist of patients who would benefit from the program, and then a volunteer is matched to each patient.

The program is being piloted on a neuro-telemetry, step-down unit, and early feedback is positive from patients, nurses, physicians, administrators, and family members. The goal is to expand the program throughout the hospital. Restraint use and patient fall rates will be evaluated to determine if the program is successful in enhancing patient safety.

Patients’ Experiences of the Relation to the Caregivers in the Ambulance – A Phenomenological Hermeneutical Study
Mats Holmberg, RN, MNSc, PhD student, Centre for Clinical Research Sörmland, Uppsala University, Uppsala, Sweden; Department of Neurobiology, Care Sciences and Society, Karolinska Institutet, Stockholm, Sweden; Kerstin Forslund, PhD, School of Health and Medical Sciences, Örebro University, Örebro, Sweden; Anna Carin Wahlberg, PhD, Department of Neurobiology, Care Sciences and Society, Karolinska Institutet, Stockholm, Sweden; Prof. Ingegerd Fagerberg, Department of Neurobiology, Care Sciences and Society, Karolinska Institutet, Stockholm, Department of Health Care Sciences, Ersta Sköndal University College, Stockholm, Sweden

Registered nurses are the caring professionals in the Swedish ambulance service. The ambulance care has a tradition of acute medical care and treatment. Along with this investigation, previous nursing studies have pointed out interpersonal caring activities as important caring complements medical treatment. From a caring perspective, these activities can be understood as establishing a comfortable and affirmative caring relationship. The aim of this study was to elucidate ambulance patients’ experiences of their relationship to caregivers. A phenomenological hermeneutical method within the perspective of caring science was used. The patients’ experiences were both negative and positive at the same time, and this can be understood as a pendulum movement. The result of the analysis is described in one main theme; To surrender independence to another. The main theme has a double-nature. To surrender means to have no other options than
to capitulate, as patients can no longer take care of themselves. This is experienced as having trust in the caregivers and is narrated as putting their life into the hands of another. Further, this surrender means to relinquish to caregivers, when the patients do not share the caregivers’ assessment of the seriousness of the disease. That is experienced as being excessively cared for. Further four themes emerged; (1) Being in the hands of another, (2) Being in a caring temporary presence, (3) Being important and (4) Being disrespected. This is a new, contextual understanding of the relation to the caregivers in the ambulance care setting from a caring science perspective, based on patients’ experiences. It elucidates the double-nature and complexity of the relationship as a caring phenomenon in the clinical practice of emergency ambulance care.

Effect of a Curriculum Based on Caring on Levels of Empowerment and Decision-Making in Senior BSN Students
Karen Johnson, PhD, RN, Nebraska Methodist College, Omaha, NE, USA

Graduate professional nurses are expected to be capable of decision-making related to complex health care issues. In order to fully participate in clinical decision-making and decisions regarding the nursing profession, nurses must feel empowered. Nurse educators are interested in discovering strategies to increase clinical decision-making abilities and empowerment of nursing students, i.e., teaching strategies and curriculum structure.

The purpose of this comparative study was to investigate whether senior baccalaureate nursing students enrolled in a curriculum based on a theory of caring reported higher levels of perceived empowerment as learners and higher levels of perceived clinical decision-making ability than senior baccalaureate nursing students enrolled a curriculum not based on a theory of caring. This study also investigated whether a relationship existed between the level of empowerment as learners and the level of perceived clinical decision-making ability in senior baccalaureate nursing students. The study was designed around a theoretical framework of caring using Boykin and Schoenhofer’s Nursing as Caring theory as well as Watson’s The Philosophy and Science of Caring.

Surveys were distributed online to senior nursing students enrolled in a university which was determined to have a curriculum based on a caring theory and to senior nursing students enrolled in a university which was deemed to have a curriculum which was not based on a caring theory. Determination of curriculum structure was based on a review of the published mission, vision, and philosophy of the nursing curricula of the two universities. Research instruments included a demographic survey, the Learner Empowerment Measure (LEM), and the Clinical Decision Making in Nursing Scale (CDMNS). Sixty-nine surveys were returned and 62 were included in the study.

T-tests were conducted to determine differences in mean scores of the total LEM and total CDMNS and each of the subscales for each instrument. No significant differences in group mean scores were found between the two groups on the LEM and the CDMNS. Additionally, no significant relationship was found between the LEM and the CDMNS. However, qualitative data obtained from students on the demographic survey provided interesting information regarding students’ perceptions of caring in their nursing program of study.

The results of this study indicate that curriculum structure may not be a contributing factor to learner empowerment and clinical decision-making of nursing students. However, the information obtained regarding students’ perceptions of caring characteristics of the nursing school/faculty is important. Further research should be conducted to determine what factors students identify as caring and whether these factors may influence empowerment and clinical decision-making.

To Establish Rapport is to Live Communion in a Caring Relationship – A Hermeneutic Semantic Exploration of the Concept “Rapport”
Anne Kasén, RN, PhD, Department of Caring Science, Åbo Akademi University, Vaasa, Finland

The aim of this study is to explore the concept of “rapport” used by the early nursing theorist Travelbee when describing the core of a caring relationship. The impetus for this study is to develop Kasén’s theory on the caring relationship between a nurse and a patient where the patient’s suffering can be alleviated. The “rapport” concept is seldom in use in nursing research as a synonym for a close relationship between the patient and the nurse. Earlier studies of the patient’s world led to two assumptions about the narrative dimension in a caring relationship and how it can contribute to the creation of this relationship. The nurse has to make room for the patient’s narrative in her world, and caring relationships call for a reflected awareness of the exposed position and vulnerability of the patient. The narrative of the patient’s suffering calls for the nurse to participate. The assumption underlying this study is that an exploration of the meaning in the concept “rapport” can expand the understanding of the caring relationship. “Rapport” might be a fruitful concept to revisit. The research question is: What does the concept “rapport” mean?

The methodological approach is a hermeneutical semantic analysis according to Sivonen, Kasén and Eriksson, whereby the conceptual family around the concept ‘rapport’ can be explored. The data consist of a purposeful sample of English thesauruses and etymological dictionaries.

The etymological investigation gives at hand that ‘rapport’ origins from mid-17th century, a derivative of French rapporter “to bring back” or to ‘report’ and also related to Old French
Native American Adolescent Stress Intervention Strategies Guided by the Nursing as Caring Theory
Melessa Kelley, RN, MSN, PhD-C; John Lowe, RN, PhD, FAAN, Florida Atlantic University, Christine E. Lynn College of Nursing, Davie, FL, USA

Adolescence is a period in life characterized by rapid physiological, social, and cognitive changes that may generate stress. All adolescents regardless of ethnicity face general normative sources of stress such as daily hassles and transition to a new school as part of their developmental processes. It is important to know how adolescents experience stress, and what they do to manage it so that adolescent-appropriate interventions can be developed. Little is known about how Native American adolescents experience or manage stress; however Native American adolescents experience stress on a continuous basis. Native American youth are known to have significantly greater stress than their white peers, often related to social and economic factors such as poverty and family disruption. Stress and coping processes play an important role in physical and mental health outcomes for Native Americans. However, coping responses to stress often leads to the use of drugs and alcohol resulting in unhealthy consequences such as, risky sexual behavior, substance abuse, drunk driving, and suicidal behaviors. Alcohol, substance abuse, and depression are among the highest causes of mortality in Native American adolescents. The mortality rates for Native American adolescents are two times higher than that of other races or ethnic backgrounds, and three times higher for Native American adolescent males. By the time Native American adolescents are in twelfth grade, over 80% are active drinkers. Stories of stress were collected from 179 Keetoowah-Cherokee Native American adolescents ranging in ages from 14 to 18 years old. The stories were collected and analyzed using the Consensual Qualitative Research (CQR) method to identify the stressors experienced by this Native American Adolescent population. The themes identified were then used to develop stress intervention strategies guided by the Nursing as Caring Theory.

Using the National HCAHPS Survey to Evaluate Caring for Patients
Beth Koon, LCSW, DCSW, CPHQ, Winter Haven Hospital, Winter Haven, FL, USA

This workshop will focus on utilization of the national HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey as a tool to measure patient’s perceptions of nursing caring at a community hospital. HCAHPS is the nationally standardized and benchmarked survey of satisfaction with adults discharged from inpatient settings. Every U.S. hospital accepting Medicare payments is required by the Centers for Medicare and Medicaid (CMS) to participate in the HCAHPS survey. Winter Haven Hospital has participated in the HCAHPS survey since its inception.

Winter Haven Hospital is one of eight Affiliate hospitals with the Watson Caring Science Institute (WCSI). We have worked with Dr. Jean Watson since 1992. Dr. Watson’s Caritas Processes are the foundation for our Nursing Professional Practice Model. We have also provided the resources for training and certification of nine Caritas Coaches through WCSI.

Caring (Caritas) is central to the identity and core of our hospital’s operations. Every meeting, including the Board of Trustees, begins with a Caring Story. The Caritas Processes are included in our employee job descriptions and performance evaluations. We have also incorporated the Caritas Processes in our electronic nursing documentation, beginning at the time of implementation. The hospital hosts an interdisciplinary Care Experience Council and a Caring Culture Team, both led by the author of this presentation.

This presentation will begin with a review of the Caring Culture Team’s cross-walk of the Caritas Processes to individual Hospital Consumer Assessment of Health Plans Survey (HCAHPS) questions. Another hospital, AtlantiCare, in Atlantic City, NJ, inspired us to this task after presenting their crosswalk of the HCAHPS Domains to Caritas Processes. Our project took us deeper into the individual HCAHPS questions. The project then expanded to training nursing leaders about the crosswalk and asking nursing leaders to teach their staff in turn.

Analysis of our hospital’s HCAHPS data will include identification of strengths and opportunities for the Caritas processes. For example, the HCAHPS scores regarding Careful Listening by Nurses, may demonstrate a need for enhanced acceptance of the positive and negative from patients and families (Caritas Process 5). The HCAHPS scores for Quiet at Night, may indicate opportunity to improve the Healing Environment of Care (Caritas Process 8).

The workshop is intended to identify HCAHPS as one indicator of patients’ perceptions of Caring, but not as an exclusive indicator.

Unraveling the Mystery Behind the Diagnosis: Using Story Inquiry to Inform Caring Practice
Mary Ann Leavitt, RN, BSN, CCRN, PhD student, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL, USA

Introduction: Attentive listening to a person’s story is a meaningful way to gather unique information about that individual from his or her own perspective. Acquiring a full
understanding of each person’s health challenge is fundamental to nursing practice. Although everyone’s story is a bit different, common themes may be identified when considering people who are facing similar health challenges. The purpose of this paper is to present story inquiry method as an approach to analyze patient stories to inform caring nursing practice.

**Method:** Story inquiry method is a theory-guided, 5-step process of story-gathering and analysis. The first step is to gather the story of a person’s health challenge, including the present experience, past history of events leading up to the present, and future hopes and dreams. The next step is to begin deciphering the dimensions of the health challenge, which are the descriptions of the individual’s unique personal experience. These descriptions determine the story plot, which is the third step of the process. The elements of the story plot are the high points, low points, and turning points, which are defined before analysis is begun. The next step is to identify actions taken that move the person toward resolving the health challenge. The final step is to synthesize the findings through the lens of a question that reflects the intent of inquiry.

**Findings:** The questions for this analysis were intended to inform caring practice by coming to know the high points, low points, and approaches for resolving the health challenge of end-stage heart failure. High points were defined as times when things are going well, low points were defined as times when things are not going so well. A story of one 78-year-old man with a diagnosis of heart failure was analyzed to provide an exemplar of the story analysis process. High points were the caring connections he had with his family, friends, and physician. Low points were the disruption caused by hospitalization and the times the promise of successful treatment failed him. Movement toward resolving was exhibited by taking control of everyday living with a positive attitude infused with humor.

**Discussion:** Nurses interact with patients and hear their stories every day. The collection of objective, diagnostic information from physical assessment and laboratory values provides an essential snapshot of the patient’s health challenge, but their stories enhance the color and focus of their experience. Attentive listening to the stories of patients can reveal new insights and evidence to better support them and meet their needs. In the case of the exemplar patient, it was critical to explore his feelings when treatments failed and to create in-hospital opportunities for him to connect with those who cared. The physical care of the patient must be accompanied by attention to the cues provided by their own stories. These cues can direct meaningful patient-centered care. Story inquiry method offers a systematic approach to story gathering and analysis with the potential to inform caring nursing practice.

**The Journey Home: Caring with Urban Appalachian Families As They Transition From Homelessness**

Rebecca Lee, PhD, RN, PHCNS-BC, CTN-A; Angela Clark, MSN, RN, University of Cincinnati College of Nursing, Cincinnati, OH, USA

"Home is where we start from, but home is also where we are bound for, the place we always seek." David Steindl-Rast

Approximately 600,000 families will experience homelessness in any given year. Over 70% of these families are headed by a single parent—most often a mother. The goal of this ethnonursing research, funded by the 2010 Leininger Human Care Research Award from the IAHC, was to discover transcultural nursing knowledge related to the experiences, meanings, and supportive care needs of urban Appalachian families during the vulnerable resettlement period that follows an episode of homelessness. The domain of inquiry for this study was the culture care meanings, expressions, and lifeway experiences related to kinship and social factors for selected African-American Appalachian and European-American Appalachian mothers caring for their children while navigating the transition process from shelter living to being housed. This presentation highlights the importance of social connectedness to caring others in the lives of these Appalachian families, as well as the pain associated with the loss or absence of connections with supportive, caring others.

The research was conceptualized within Leininger’s Theory of Culture Care Diversity and Universality. Data collection took place over a 12-month period with eleven key participants of Appalachian cultural heritage (five African-American and six European-American) and twenty general participants. Observation, participation, and ethnographic interviews were used to collect in-depth data within the complex and chaotic context of the participants. A systematic, rigorous, and in-depth data analysis was completed, grounded in Leininger’s four phases of analysis for ethnonursing qualitative research data. Evaluation criteria of credibility, confirmability, recurrent patterning, meaning-in-context, redundancy, and saturation were met.

Interviews were initiated with each mother while she was living in the shelter, and then continued during the weeks and months after she moved into housing with her children. Throughout each of these caring encounters, mothers spoke at length regarding personal meanings and experiences related to the need for human connectedness in order to facilitate this challenging transition. Rather than asking for a “hand out,” these mothers simply longed for the warm embrace of a caring hand to support them along their journey toward home. In the end, isn’t that all any of us are really looking for after all?
Developing Caring Content of an E-Learning Program from the Patient and Nurse Point of View
Jane Lee-Hsieh, RN, MSN, Tzu-chuan Hsu, RN, MSN; Michael A. Turton, MA, Su-Fen Cheng, RN, PhD, School of Nursing, National Taipei University of Nursing and Health Science, Taipei, Taiwan, ROC

Background: To promote the quality of nursing care, a Taiwan Hospital committed to implementing its SHARE (“S: Sense people’s needs before they ask,” “H: Help each other out,” “A: Acknowledge people’s feelings,” “R: Respect the dignity and privacy of others,” “E: Explain what’s happening”) framework in clinical practice. This research is the second stage of a three-year research project.

Purposes: (1) To explore patient experiences of caring as demonstrated by nurses in this hospital; (2) To incorporate patients’ perceptions in this study and the results of the previous research, the creation of videos of exemplary nurses role modeling caring to produce an online continuing education program in order to promote the quality of nursing care at the hospital.

Methods: This study used qualitative methods to conduct semi-structured in-depth interviews with 11 hospitalized patients. A constant comparative method was used to extract caring themes which were integrated into the five components of SHARE.

Results: Results showed that while nurses had a rich and multifaceted concept of caring, the patients focused on the physical aspects of caring. The patients also spontaneously gave many examples of uncaring behaviors. Seven themes clustered, encapsulating patient experiences and perceptions regarding caring in nursing: frequently check physical condition, provide skillful care to fulfill needs, resolve distress, give positive support, display an intimate attitude, respect privacy and autonomy, and explain current and coming intervention. Eight themes regarding uncaring in nursing were extracted: rote nursing care, neglect of physical care, refusal of patient requests, impatient appearance, insincere work attitude, not considerate of patient feelings, ignore privacy and dignity, and intervention without explanation. Based on these findings, this project combines the patient voice, presented in audio format online, with the videos of exemplary nurses, to create an online education program that exploits the potential of anywhere, anytime, streaming media.

Conclusion: These findings are used to develop caring content of an e-learning program for nursing continuing education in Taiwan.
Use of Ray’s Transcultural Caring Dynamics in Nursing and Health Care Model as Guide to Understand the Well-Being of Muslims in the United States
Mary Brigid Martin, PhD(c), RN-BC, CTN-A, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL, USA

Muslims currently represent a growing segment of the American population increasingly encountered in the health care setting. Since the tragic events of September 11, 2001 caused by individuals of the Muslim faith, this group has been subject to suspicion and scrutiny about their culture, values, beliefs, and behaviors. There is growing concern for the health impact and health care disparity related to the discrimination faced by Muslims in the United States today. The rich religious and philosophical values held by Muslims impact their views and attitudes toward health and wellness in unique ways. These significant dynamics call attention to nurses to learn about the Islamic faith, the interface of Muslims with American society, their health care needs, and well-being. Ray’s Transcultural Caring Dynamics in Nursing and Health Care model is selected as a suitable framework to appreciate the religious influences, caring expressions, ethical principles, and contextual influences of this group. The purpose of this presentation is explore the well-being of Muslims in the United States using Ray’s model as a conceptual guide for awareness, understanding, and choice within the nurse-patient relationship.

Enhancing Holistic Healing at the Workplace
Lalitha Mathew, RN, BSN, CRRN, Moss Rehab at Einstein Elkins Park, Elkins Park, PA, USA

Nursing incorporates healing with care. Caring and healing relates to the innermost core of nursing. Caring for our patients enable us to heal them. It also enables one to understand the suffering of a sick individual. By caring, one builds a connection between the patient and the nurse. That connection helps us to create a close relationship with patients.

We are entering a new level in the scientific mechanism of understanding which faith, belief, and imagination can actually unlock the mysteries of healing. Beliefs may start in the mind, but can end up in the body and spirit.

It is our responsibility as nurses to take care of our patients holistically (mind, body, and spirit). Holistic nursing is not just healing someone’s disease, but it is rather healing the mind, body, and spirit. It is bringing them together in complete unison and harmony. Ultimately, holistic nursing assists the nurse in recognizing the mind, body, spirit interaction in a patient and offering an excellent approach to quality nursing care.

This paper presentation will discuss how to discover and enhance the holistic healing of a person.

Teaching the Core Values of Caring Leadership
Judy B. McDowell, RN, MSN, CCRN; Donald D. Kautz, RN, PhD, CRRN, CNE; Randy L. Williams, RN, MSN, MBA, Wake Forest Baptist Health, Winston-Salem, NC, USA

Developing and nurturing our leaders is something that we need to do better in nursing, healthcare, and many other professions. We often fall short in orienting, mentoring and preparing them in order to ensure their future success. We may not consider their capacity to lead, or their ability to interact with others in a way that inspires and engages. We need to evaluate their ability to guide others and help them to flourish.

When we began working in this field, we became aware that teaching and role modeling the principles of caring and leadership, in a caring leadership model framework, could support and encourage major change in the culture of an organization. The Caring Leadership Model© that we constructed blends Jean Watson’s Caring Theory with Jim Kouzes and Barry Posner’s Leadership Theory. This model clarifies our leadership responsibilities and is aligned with our motivation to work in an industry that is critical to the health and well-being of our communities.

We have utilized this Caring Leadership Model© with over 200 of our nurse leaders within our organization. We have developed a caring leadership curriculum, with appropriate educational and reference material, interactive scenarios, and reflective practice initiatives. We have had our participants complete personal stories of caring leadership that demonstrate exemplars of clinical excellence before, during, and after their completion of segments of our caring leadership course. We have a study of the use of this model that is being proposed to our organizational Institutional Review Board at this time.

The Caring Leadership Model© provides a way to encourage and demonstrate the five core values of a caring leader. It marries the most widely recognized caring and leadership theories to create a solid basis for the growth and development of leaders. In our experience, we have found that these five core values are essential to success for any leader in today’s healthcare environment – especially if success is defined by how a leader cultivates and enriches the human condition.

McDowell-Williams CARING LEADERSHIP MODEL©
Five Core Values
1. Always lead with kindness, compassion, and equanimity
2. Generate hope and faith through co-creation
3. Actively innovate with insight, reflection, and wisdom
4. Purposely create protected space founded upon mutual respect and caring
5. Embody an environment of caring-helping-trusting for self and others

We believe that loss of trust and confidence in our leaders and organizations is at the root of the workforce
issues that we face today. Where these challenges have existed, we have seen the Caring Leadership Model© and supporting educational programs play an integral role in developing leaders who are eager to engage with staff and colleagues, and adept at creating space for authenticity and mutual respect. We believe it is possible to create environments that allow leaders to live agreed-upon values and encourage and promote flourishing of the human spirit in the workplace. Ultimately this creates not only an immediate positive benefit but a culture shift that produces exceptional results that are sustainable.

Family Caregivers of Wounded Warriors
Denise Miner-Williams, RN, PhD, CHPN; Sharon Lewis, RN, PhD, FAAN; Denise Kirmse, MS; Jennifer Kretzschmar, BS; Martha Loomis, MA, University of Texas Health Sciences Center San Antonio, School of Nursing, San Antonio, TX, USA

Purpose: This presentation will provide a synopsis of the results of a focus study and a feasibility intervention study in order to describe and give voice to the lives and needs of the family members who are providing long-term and sometimes life-time care for their loved ones injured in service to our country.

Introduction: There has been an influx of wounded from the longstanding conflicts ongoing in Afghanistan and Iraq. More than 15,400 service members have sustained casualties that have been severe enough to prevent return to duty. Many of these military have regained self-sufficiency, but many others require the assistance of family members in daily living. As the prior military and their families as re-enter the civilian world after leaving the service, they are going to civilian healthcare providers. Many healthcare providers have never been exposed to the military culture before and may find that the care that they provide for this population may be enhanced by acquiring an understanding of the experience of wounded warriors and their families.

The healthcare community is giving long, overdue recognition to the important and valuable contributions of family caregivers,, including those who care for wounded military members. While rewarding, family caregiving takes a great toll on the physical and emotional well-being of family caregivers.

Method: Focus groups were held to identify the stressors of military family caregivers and to determine the suitability of adapting an evidence-based stress management program for caregivers of persons with dementia to meet the needs of the military. A feasibility study, concluding in June of 2013, is underway to adapt and provide the Stress-Busting Program for family caregivers of wounded warriors. The program is a 9-session psychoeducational offering in a support group setting facilitated by two facilitators. Results are measured by data collected from baseline, exit, and 2-month post-intervention questionnaires, and from qualitative data collected from participants.

Results: The results of the focus groups indicated that the stressors, manifestations of stress, and many concerns of the military caregivers were similar to what is in the general caregiver literature. These categories were uncertainty, loss, role changes, relationship changes, and dealing with guilt.

The adaptation of this evidence-based program required some modifications to meet the needs of this community. Preliminary quantitative results indicate the trend that this program contributes to a decrease in depression and caregiver burden, and increase in quality of life. The qualitative data document personal growth and coping skills.

Conclusion: Family caregivers provide an important role in our healthcare system, but the stresses of this role take a toll on their wellbeing. When the wellbeing of the caregiver is threatened, it follows that the patient is in jeopardy. It is important that nurses be aware of and recognize family caregivers, taking action to promote their well-being. This presentation will offer guidance on how to do so.

Listening to the Cellist, the Dressmaker, and the Chef: Knowing Caring through Literature and other Arts
Mary O’Connor, PhD, RN, FACHE, School of Nursing, Notre Dame of Maryland University, Baltimore, MD, USA

At Notre Dame of Maryland, students are accepted to the University as pre-nursing students and the nursing course sequence begins in the fall of their junior year. The Nursing faculty believes that having early contact with these students is essential for the students to begin to experience the culture of nursing. We began to teach the freshman experience course offered by the School of Arts and Sciences. This course has three overarching objectives. The first being an intentional learner; this includes developing visual, written, verbal fluency, and information literacy, and gaining the ability to critically evaluate information sources. Second, is to develop an appreciation for diversity. This begins by exposing students to cultures different from their own, hopefully developing a global outlook. Third to become a Notre Dame Woman, embracing values such as self-reflection; developing leadership skills and a sense of social responsibility; developing a moral or ethical compass; and identifying the role of spirituality in one’s life. The course meets these objectives through literature, film, theatre, cultural events, and service learning projects, with a focus of strong women role models as well as introducing the students to a range of campus resources and college study skills.

The course was a challenge for nursing faculty to step out of the clinical comfort zone. We decided that we would use the structure of the course to begin weaving the concept of caring with Mayeroff (1971) and Watson (2008) throughout the content.

Students explore the concept of caring through popular fiction and non-fiction. This year’s literature included the The Cellist of Sarajevo by Stephen Galloway, The Dressmaker of
Khair Khana, by Gayle Tzemach Lemmon, and The School of Essential Ingredients, by Erica Bauermeister. All three stories featured strong women characters who demonstrated caring in different ways and under different circumstances. In addition to the literature, caring is illustrated through art and an assessment of the caring aspects of the University Campus (Stowe, 2006).

This presentation explores the freshman seminar experience and demonstrates ways of instilling a culture of caring in freshman pre-nursing students.

Calling the Hermeneutic Circle: Being and Longing with Pre-Nursing Students
Mary T. Packard, PhD, RN; Jenna K. Forte, MS, Notre Dame of Maryland University, Baltimore, MD, USA

- Hermeneutic experience has its own rigor: that of uninterrupted listening. (Gadamer, 1960/2000, p. 465)
- Understanding nourishes belonging. When you really feel understood, you feel free to release yourself in to the trust and shelter of the other person’s soul. (O’Donohue, 1997, p. 14)
- I usually cloak myself – never share my true feelings. I never do this...The light from the candle is a new beginning. (Ashley, Personal Communication, 2012)

Caring as the essence and moral imperative of nursing serves as the foundational core of the discipline of nursing (Watson, 2008) – leading and inspiring the creation of our lived and planned curriculum in our new baccalaureate nursing program. We are unfolding in the midst of established RN to BSN and MSN programs – faculty and staff and students – being and becoming. We recognize the tension in the space where the dominant technical paradigm meets interpretive questions of meaning. Our students worry about success in basic science courses; some fear not meeting the progression requirements. They are thrown into new ways of being and doing and wrestle with transitions, academic and personal. Living the phenomenon of caring makes it necessary to create pedagogical places for dwelling together in essential ontological questions – questions of what does it mean to be a pre-nursing student? What does it mean to be a person becoming a nurse? What is the lived experience of care and caring?

In our School of Nursing, the Chair of Undergraduate Nursing and Retention Specialist intentionally gather in caring structures with pre-nursing students as a presence of being, support and encouragement along their currere, their journeys of nursing education. We engage in circles of caring to include: Summer Bridge pre-college program for select students, Teaching Assistant (tutoring program), and a monthly Caring Circle. Committed to the practice of becoming and understanding – we call the circle in each one of these caring structures. Responding to the call, we engage with our students in the rigor of “uninterrupted listening” – we dwell in the “hermeneutic circle” (Heidegger, 1996, p. 153).

In this paper, students’ spoken and written reflections as well as shared dialog become human science text that is oriented, strong, rich, and deep (van Manen, 1990). In the presence of care and caring in the circle, essential themes of longing, belonging, and comfort emerge as we explore the lived experience of being a pre-nursing student. A sense of community is strengthened as “understanding nourishes belonging” (O’Donohue, 1997, p. 14) within the caring circle. Being in the caring circle offers radical possibilities for a pedagogy of being and becoming.

Unraveling the Mystery of the Magical Mechanisms to Portray Human Caring via the Miraculous Internet
Robin E. Pattillo, PhD, RN, CNL, University of Iowa College of Nursing, Iowa City, IA, USA

The internet has provided a magical, miraculous, and a bit mysterious opportunity for nurses to further their education. Practicing nurses and those who want to be nurses are able to reach educational and professional goals and overcome limitations of place and time via online education. However, since the inception of online nursing courses, many of us have wondered about human caring using this miraculous technology. Can we role model human caring via the internet? Can our students perceive our caring? Can students learn human caring through interactions with one another and with their instructors through the internet? When the majority of our own caring interactions occur via the internet, how do we care for ourselves? Teaching online opens up an assortment of opportunities to be misperceived as uncaring, but can provide creative new ways to exhibit human caring. This presentation will review best practices to employ human caring in online courses. Strategies that have been perceived by students as illustrating human caring in online courses will be presented. Also, methods to care for oneself when working on the internet will be addressed. Thus the mystery of human caring on the internet will be addressed with magical mechanisms that will potentially achieve miraculous results.

Caring and Uncaring Behaviors from the Perspective of Patient: A Qualitative Study
Xiao Peng, MSNc, RN, Yilan Liu, PhD, RN, Department of Nursing, Union Hospital of Tongji Medical College, Huazhong University of Science and Technology, Wuhan, China

Background: Caring is the essence of nursing that produces therapeutic results in the person being served. No caring is no nursing. Nurses’ caring behavior has been explored in a number of studies. Most of them focus on caring aspects. However, few of them pay attention to nurses’ uncaring behaviors and actions from the perspective of patients.
Objective: The aim of this phenomenological study was to explore how patients experienced nurses' caring and uncaring behaviors and actions during hospitalization, in order to improve nursing service and patients satisfaction ultimately.

Method: A qualitative study was used. Data were collected through in-depth interviews with 15 hospitalized patients at the beginning of 2012 at a comprehensive hospital in China. Data were analyzed by using content analysis, which is an inductive process.

Results: The findings were subsequently classified according to themes of caring and uncaring. The caring themes from the perspective of patients include such aspects: psychological support, mutual respect, being considerate and thoughtful enough, being excellent in nursing skills, quick response to patients' request, appropriately informing patients of disease condition. The uncaring encounters were generalized as the followings: lack of effective communication skills, some lack of sufficient professional knowledge to cope with patients' problems, poor maintenance of ward environment, medical resources in short supply; 93.33% of patients experienced caring and 33.33% experienced uncaring.

Conclusion: The result showed that there still exist some potential aspects that nurses can strive to make a difference, such as improving communication skills, enhancing professional knowledge, maintaining a quiet ward environment and so on, in the expectation of providing patients with much more caring in today’s complex healthcare system.

Magic, Mystery, and Miracles in Oaxaca, Mexico: Ritual and Healing Among Indigenous People

Joyce B. Perkins, PhD, MS, MA, RN, AHN-BC, CHTP, RMT-P; Katherine Baumgartner, RN, DNP; Joyce Miller, RN, DNP, RMT-P, Augsburg College Department of Nursing, Minneapolis, MN, Rochester, MN, USA

This presentation shares “caring” practices with pan dimensional implications. Students in an Augsburg College Department of Nursing course are immersed in ancient traditions honoring the children and the ancestors of village people in Oaxaca, Mexico. El Dia de los Muertos is a ritual meant to lovingly remember relatives who have died. By honoring one’s relatives in ritual, human existence is given renewed meaning and continuity. Emphasis is on the meaning of rituals associated with this traditional celebration and other healing ceremonies. A sense of continued relationship between the living and the dead, extending beyond the grave, reveals a cosmology of rhythms and cycles that are usually lost to the Western, linear, rational thinking world. Deep relationship with the natural environment reveals healing potentials, along with expanded perception and awareness, that unpack “caring,” or the focus of “attention and intention” in nursing via expanded ways of knowing. The skies are seen to fill with “orbs” as the ancestors are invited to participate in the celebrations. A sense of a “unitary” world, where local and non local fields of intelligence and heart combine, create mysterious avenues for transformation and healing. Nursing students on this journey learn to embrace and integrate multiple ways of knowing into their nursing praxis. They return to the Western world with renewed enthusiasm, and a sense of wonder that revitalizes the spirit of each, as “care” is seen to extend beyond boundaries and borders of conceptual models and hospital sterility. Relationships and community come alive in new ways.

The Role of Caring in The Human Health Experience: Magic, Medicine, and Healing

Joyce B. Perkins, PhD, MS, MA, RN, AHN-BC, CHTP, RMT-P, Augsburg College Department of Nursing, Minneapolis, MN, Rochester, MN, USA

This presentation offers the wisdom, experience, and pictures of a nurse engaged in healing practices and nursing education for 40 years. How caring facilitates healing and an expanding consciousness is articulated through the voice of nursing theory, indigenous wisdom, transcultural perspectives, western science, complexity science, consciousness studies, and spiritual practices. A “Unitary Caring Science” is developed via examination of nursing paradigms, quantum physics, cosmology, sacred geometry, and traditional native understandings of healing and working with the natural environment and cosmos. Understanding the universe as a fractal hologram allows for development of pan dimensional awareness within the nurse/client relationship and within the larger context of family, culture, globe, and cosmos. How the nurse maintains awareness of both the “local” and “non-local” environment, as well as experiences states of joy, mystical bliss, and inner knowing, is embedded in educational practices of meditation, caring art/science, Heart Math studies, and studies of the natural world found in indigenous life and transcultural nursing. The nurse able to embody “sacred space” is coming of age. Healing via multiple dimensions is revealed along with language to support the larger understanding and concepts evolved. Energy healing praxis unpacks the role of resonance, coherence, harmony, and inner peace as they interface with healing at the level of the Soul and expand to efforts for global peace. Love/care are key to unlocking potential in humankind. An educational program for nurses developed at the level of Master Degree and Doctor of Nursing Practice is shared.

See The Beauty of the Dancer

Carol Picard, PhD, RN, President, Carol Picard Associates, North Port, FL, USA

Everything that rises must converge. Flannery O’Connor

This performance/presentation is a nurse researcher/artist’s autoethnography. As a researcher, I had explored the
The Theory of Human Caring supports the themes and the
Watson's Theory of Human Caring and her Clinical Caritas.

Robb's Reiki Model is congruent with
the subjective, caring interaction between a nurse and a patient.

Identified 10 carative factors that are unique to the distinct,
nursing and the values inherent in this interaction. Watson
Theory incorporates the uniqueness of the caring occasion in
Watson's Theory of Human Caring. The tenets of Watson's
findings of this study can be viewed within the context of Jean
Healing, and Healing Effect. Applications of Jean Watson's

Caring as Evidenced in the Lived Experience of
Registered Nurse Reiki Practitioners

Wendy J. Robb, PhD, RN, Cedar Crest College,
Allentown, PA, USA

Background and Significance: The use of
complementary and alternative modalities (CAM) has
increased. Healthcare consumers spend billions of dollars on
a variety of CAM therapies annually. Reiki is an energy-based
CAM therapy derived from practices of Tibetan monks.

Proponents of Reiki believe that unblocking or redistributing
the body's natural energy facilitates self-healing.

Objective: The purpose was to describe the lived
experience of RNs who administer Reiki treatments to
themselves and/or others.

Study Design: This study used a qualitative
phenomenologic design. Interviews were conducted via email.
The purposive sample was comprised of 19 participants from
15 states. Ricoeur's Interpretation Theory was utilized in data
analysis including identification of preunderstandings, the
naïve read, open coding of the transcripts, construction of
structural meaning units, development of themes and sub
themes, and ultimately the emergence of a preliminary model.

Results: A four-part model depicting the lived experience
of RN Reiki practitioners was constructed. Robb's Reiki Model
includes: Initiation to Reiki, the Art of Reiki, Platform for
Healing, and Healing Effect. Applications of Jean Watson's
Theory of Human Caring and her Clinical Caritas are evident.

Caring Implications for Practice: Theoretically,
the findings of this study can be viewed within the context of Jean
Watson's Theory of Human Caring. The tenets of Watson's
Theory incorporate the uniqueness of the caring occasion in
nursing and the values inherent in this interaction. Watson
identified 10 carative factors that are unique to the distinct,
subjective, caring interaction between a nurse and a patient.
Seven major elements of the lived experience of RN Reiki
practitioners identified in this study can be correlated to the
10 Clinical Caritas. Robb's Reiki Model is congruent with
Watson's Theory of Human Caring and her Clinical Caritas.
The Theory of Human Caring supports the themes and the
model and elucidates caring evident in the practice of RN
Reiki practitioners.

The Integration of Caring Science within Nursing
Simulations as an Effective Teaching Strategy in
an End-of-Life Course at a Registered Nurse-
Baccalaureate Program

Janet Sopcheck, RN, MA, CCRN, CEN, CAN, Broward
College, Davie, FL, USA; Dr. Linda Washington-Brown;
Dr. Arman Davis; Dr. Angela Russell; Dr. Christine Williams,
Christine E. Lynn College of Nursing, Florida Atlantic
University, Boca Raton, FL, USA

Introduction: In caring for individuals and their families
at the end of life, effective communication is essential in
addressing the complexities of grieving and encouraging
healing. Applying concepts from caring science theories
substantiates a framework for end-of-life care communication
which encourages nursing insight and knowledge relative to
the lived experiences of the patients and their families.

Through caring, meaningful relationships are established
which may ease the pain and suffering of patients and their
families. It is the caring moments within nursing situations
where thoughtful empathetic expressions are emphasized,
fostering a connectedness between nurses and their
patients/families facing this difficult process. Within simulated
nursing situations, nurses conceptualizing caring learn
effective communicative strategies to create caring moments
through reality-based patient scenarios.

Methods: Within this eight-week End-of-Life course,
14 hours are devoted to pedagogical methods on theoretical
aspects of end-of-life care. Four three-hour sessions within
the course provide reality-based simulation exercises on
caring for one patient with a terminal diagnosis as he/she
experiences the final stages of life. Each week, nursing
situations which are patient-family centered are conducted
either using a simulation manikin with scripted external voice
direction or through role playing employing standardized
patients or students as the actors. A debriefing session
tered a reflective mapping is held after the simulation,
facilitated either by a faculty member or a student, to
discuss effective caring strategies and recognize missed
opportunities. Within reflective mapping, caring concepts
are explored relative to the effectiveness of verbal and
non-verbal communication within the "lived experience"
simulation exercise.

Results: At the completion of this first End-of-Life
course, students expressed positive feelings about their ability
to care for patients at the end of life. Students' knowledge on
death and dying was enhanced through use of lecture and
simulation learning strategies. Student feedback related to
simulation was extremely positive as participation in reality-
based situations offered them the opportunity to learn
effective empathetic conversations vital in caring for patients
and their families at the end-of-life. Simulation provided the mechanism to illustrate lived experiences grounded in nursing’s caring and to assist students to create caring moments with effective communication.

Discussion: Reality-based simulation exercises were shown to be a valuable and effective learning method to embrace end-of-life communication in nursing’s caring. These exercises enhanced students’ knowledge of caring for the terminally ill patient during the dying process and further elaborated their cultural and ethical perspectives using reality-based scenarios. In analyzing this preliminary course, the course developer determined the need to incorporate specific caring theories to further validate the application of caring science within simulation praxis. Current theories on caring will be evaluated for use in future courses within simulation exercises to substantiate a theoretical framework that supports and fosters effective communication strategies and living nursing’s caring for patients and their families at the end-of-life.

From Midwife/PhD Candidate to Midwifery Lecturer – The Practical Application of Lessons Learned and Transferred from Attending Previous International Association for Human Caring Conferences
Tina South, RN, PhD(c), University of West London, Brentford, Middlesex, England, UK

The presenter will chart her journey from Midwife/PhD candidate to Midwifery Lecturer and how membership of the IAHC and attending two previous IAHC conferences played an instrumental part during her application process. The influence of lessons learned and transferred from San Antonio and Philadelphia provided the impetus for the creation of a caring circle cross year groups for student midwives at the University of West London. Survey Monkey, a free online survey and questionnaire tool was used as a means to determine dates and times that were convenient for the majority of students to attend this extra-curricular activity. A discussion of the International Association for Human Caring and Jean Watson’s Ten Carative factors were initially used as a way to promote the science of caring. Feedback from the students who have participated will then be considered before outlining plans for future development of this caring circle.

Nursing “Caring” During Catastrophic Events: Theoretical, Research and Clinical Insights
Yvonne M. Sterling, PhD, RN, AE-C, Louisiana State University Health Sciences Center School of Nursing, New Orleans, LA, USA

The purpose of this presentation is to describe and examine the care delivered to disaster survivors within the context of selected caring concepts, theories, and models. Natural disasters are international ubiquitous events that cause immeasurable human suffering, significant injuries or premature death. Nurses have had significant roles during all phases of such catastrophic events. There is a plethora of interdisciplinary and international literature that describes nurses’ experiences during natural disasters, particularly the Asian Tsunami, the earthquake in Haiti, and Hurricane Katrina.

Additionally, there is an abundance of descriptions of nurses’ personal values and needs including spirituality, and how they addressed environmental issues that threaten their/patients’ safety and wellbeing. There are depictions of nursing practices that include traditional and innovative interventions and how they addressed psycho-emotional factors that influenced nurse-patient relationships as well as that with the health care team. For example, nurses described their compassion and advocacy for women, children and families before, during, and after Hurricane Katrina. Also, it was noted the need to care for themselves as well as other health care providers as they experienced fatigue, distress, grief and uncertainty while meeting the needs of vulnerable patients in a chaotic and unsafe environment.

Without question, nurses have been an intricate component of the care delivered to disaster survivors. Key concepts that are associated with the fundamental nature of caring include empathy, compassion, availability, and communication. Several caring conceptualizations, models and theories such as those of Hallldorsdottir, Leininger, Sumner, and Watson, provide potential frameworks to guide disaster nursing practice. However, in this era of evidenced based care, how congruent and applicable are these theoretical and philosophical perspectives to the current descriptions of nursing care during catastrophic events? Implications for existing and new caring theories as well as research on disaster nursing practice will be recommended and discussed.

The Application of Caring Concepts as Strategies for Recovery Success
Ross A. Stewart, RPN, RN, MHSc, Executive Director, Marineview Housing Society, West Vancouver, BC, Canada

This experiential and interactive presentation will outline the integration of caring concepts in a recovery oriented residential facility for adults living with major mental disorders. Also included will be an opportunity to discuss the utility of the caring concepts and share ideas and experiences with application in other settings.

Recovery concepts have become a major force in the mental health rehabilitation movement. The facility being described has implemented an overall recovery focus as part of its psychosocial rehabilitation framework.

Caring concepts in nursing have been explicated most extensively, and I believe, most effectively by Jean Watson. Other theorists have built on this work. A brief review of the origins and development of caring concepts will provide some
Introduction. Among the sciences, nursing is a profession that encompasses the science of caring. Caring in nursing is what transforms the ordinary into the miraculous while in communion with a patient. Mystery is uncovered while in a nurse-patient situation and magic ensues bringing hope, faith, love and healing into the relationship. Nursing is not just a profession; it is a meeting place where the expression of hope, faith, love, and healing is revealed in the nurse-patient situation as an unfolding of persons living in caring. The student nurse preparation necessitates the science of caring in curricula in order for the student to fully profess nursing. Furthermore, caring provides meaning that sustains a nurse though a career journey and patients recognize that it is with caring that comfort and satisfaction is found. The purpose of this paper is to advocate for the inclusion of the science of caring in nursing curricula; answering the call for a comprehensive education for the full scope of the practice of nursing.

Theoretical Lens. Nursing is posited as nurturing persons living caring and growing in caring (Boykin and Schoenhofer, 2001). In the theory of Nursing as Caring, the key concept is the nursing situation (Boykin and Schoenhofer, 2001). In the nurse-patient situation a place is created for an unfolding and transformation between the nurse and the patient where faith, hope, love, and healing may ensue. The nurse-patient situation provides a meaningful unfolding where knowledge develops and healing takes place. Through the use of a caring science in curriculum, students will be exposed to theories in caring with emphasis on the nursing situation. During the nurse-patient situation, students will discover forms of caring and ways of knowing as expressed through Carper (1978); personal knowing, empirical knowing, ethical knowing, and aesthetic knowing. This process will unveil the depth of the act of nursing as students recall their nursing situations. Resultant to the recall of the nurse-patient situation, relationships are validated through verbal expression. Students are empowered with knowledge and patients express improved outcome. Boland (1988) states that a curriculum organizing framework lends vision to a discipline’s scope of knowledge. The scope of knowledge in nursing begins in the nurse-patient situation.

Advocacy Statement Results. Because caring is a relational phenomenon that is embedded within the practice of nursing, relationships in nursing are encouraged. Relationships are not only cultivated in the nurse-patient situation, they are vehicles for living deeper caring moments.

Discussion. Nursing is a profession that seeks to nurture persons living caring and growing in caring. In the nursing situation caring comes to life when meaning and healing unfolds. Nursing curricula embracing the nurse-patient situation provide a student a caring knowledge and a meaningful understanding of relationships, while preparing to embark upon the nursing profession.

Cultural Impact with Reflective Journaling
Donna Taliaferro, RN, PhD, Holly Diesel, RN, PhD, Goldfarb School of Nursing at Barnes Jewish College, St. Louis, MO, USA

Reflective journaling is a way to improve one’s practice and explore feelings about certain things that are being experienced for the first time. Journaling helps students to enhance critical thinking, problem solving and improved overall confidence in their work (Billings, 2006; Craft, 2005; Diekelmann, 2003) A mixed method descriptive study was conducted in order to explore the impact of a cultural immersion experience on nursing students’ knowledge, attitudes, perceptions, and reflections. Research using a train-the-trainer model was the method of the qualitative section of the study. This paper addresses only one portion of the qualitative piece: reflective journaling.

Immersion programs have identified the value of self-reflection within a new area and have the ability to change the way in which students view the world. Knowing that change may be slow within an environment that has different cultures that may or may not be seen on a regular basis, an intense immersion program into a different culture can make change occur more quickly.

Four themes emerged from the students’ journals. Change, Conflict and Chaos, Leaving Home Behind, Recognizing the Effect of Poverty, Making Do, and Making a Difference. Each theme will be discussed using the words of the students as they embarked on an international immersion trip into Africa.

The implications of these findings can extend beyond the borders of our own country into those unknown to many. Through analysis of their own feelings and interactions, they will begin to understand the perspective of their patients.
The ART of Reaffirming Purpose in Health Care Practice
Vidette Todaro-Franceschi, RN, PhD, FT, Hunter-Bellevue School of Nursing, Hunter College, City University of New York, New York, NY, USA

The carer’s professional quality of life is becoming an increasing concern. Research findings continue to accrue which indicate that there is a significant relationship between how we in the health-related professions provide care and how we feel about our work and work environment. Compassion fatigue and burnout are two significant syndromes which are reaching epidemic proportions in many occupations and unfortunately, many carers are not aware that they and/or their coworkers are suffering from these syndromes. Poor professional quality of life impacts productivity in the workplace and ultimately diminishes the quality of care rendered to people – people who are counting on us to care and to do it well. Hence the reason why the word carer is used instead of caregiver – it is to emphasize that we do not just provide or give care, we care.

Countless individuals have emphasized the potential detriment to self that can arise from the unique work of health care professionals; however, we are not victims. There are things that carers can do to heal from and/or avert compassion fatigue and burnout.

A therapeutic model has been developed to assist health carers to enhance their professional quality of life. The acronym ART is used to describe three overlapping steps: A-acknowledging feelings or a wound (i.e., compassion fatigue, moral distress, death overload, burnout); R-recognizing choices that one can make and taking purposeful action to re-enchant, and reaffirm purpose in one’s work; and T-turning outward toward self and others-reconnecting with ourselves, our patients, coworkers and loved ones.

Acknowledging that there is a problem is accomplished by becoming more mindfully aware of how we are going about our work. For example, perhaps one is uncomfortable going to places that scare them, like caring for a patient who is dying. Or perhaps one is working with a staff member who appears burnt out, and is bullying others in the workplace. Once we identify the problem, we need to recognize that we always have a choice in how we go about our work and we can choose purposeful actions that foster and enhance our connectedness – our sense of we-ness.

Purposeful, compassionate, caring acts are the essence of our work, and they are powerful in that they enhance the quality of living–dying for our patients, their loved ones, and for us, the carers (and indeed our loved ones). Given the previously mentioned examples, maybe one needs to learn how to communicate and be more comfortable with individuals who are dying and his/her loved ones, especially if working in an environment where dying and death is a frequent occurrence. Or perhaps one needs to speak with and try to understand the behavior of the coworker who appears dispassionate. Turning outward towards ourselves (and others) and being mindfully aware of how one is caring for self (and others) and what contributes to one’s feelings of contentment can help carers reaffirm purpose in their workplace and lives. This in turn will positively transform quality caring for all.

Transforming Practice through Embracing Caring in Nurse Managed Centers
Kathleen Valentine, RN, MS, PhD; Eugenia Millender, PhD(c), RN, MS; Maria Ordonez, DNP, ARNP-BC, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, FL, USA

Caring is a complex and multi-dimensional concept. As it relates to nursing, its core is comprised of who the nurse is (attributes, affect) what the nurse knows (cognitive knowledge) and how that is put into action (competence, professional vigilance) in interactions intended for healing, comfort or teaching/learning. The quality of interaction in patient care encounters is affected by philosophical beliefs that shape practice design, delivery, and structural aspects of the practice environment such as resources, technology and staffing (Valentine, 1997). This paper will describe the structure, process, and outcome dimensions within two nurse managed centers (NMC) philosophically and operationally guided by caring science. The centers address the epidemics of diabetes, Alzheimer’s disease, and related dementias.

The special emphasis of our NMC on diabetes prevention, education, and treatment reflects the needs of the diverse community. Diabetes takes a huge toll in Florida where 1.3 million have the disease and an additional 2.5 million are at risk (Galewitz, 2007). With rising obesity in the population, one in three people born after 2000 can expect to develop diabetes in their lifetime. For Blacks and Hispanics, the risk is one in two. The NMC is certified by American diabetes Association as a provider for diabetes self-management programs which have been shown to lower health care costs, hospitalization rates, emergency department visits, and to improve clinical indicators such as blood sugar levels (Rosenzweig, 2010).

Our Memory and Wellness Center is led by a DNP geriatric nurse practitioner and a team of providers including neuropsychologists, social work, and physical therapists. The memory center provides comprehensive memory evaluations, an adult day center providing services for 68 persons per day with mild or moderate cognitive impairment, and caregiver support services for 100 persons a week. The clinics represent a $2 million dollar a year annual operation providing sites for care to over 8,000 persons. The centers serve as a vibrant learning laboratory for faculty and students to experience the beauty and mystery of the human life experience as lived, studied, and researched through caring in action.
Our NMC’s evidence-based programs for specialized care combined with complementary holistic wellness approaches are critical to both the improvement of health and well-being, and the reduction of costs of care. The impact of the healing relationship of this clinical nursing model and the difference caring makes is evaluated through intersubjective, interobjective, interior and exterior individual and collective measures (Quinn et al., 2003). Impact related to diabetes self management, community screening for diabetes, caregiver support, fall risk prevention, and a mindfulness program for children at risk for obesity will be highlighted as an example.

The Lived Experience of Nursing Faculty Who Receive Caring from their Students
Susan Welch, EdD, RN, CCRN, CNE, University of West Georgia School of Nursing, Carrollton, GA, USA

The purpose of this phenomenological study was to explore the lived experience of nursing faculty who received caring from their nursing students. Seven faculty members participated in the research. These faculty members had experiences teaching in a nursing program within a caring curriculum and had acted as facilitators for caring groups. The interviews were analyzed using a phenomenological methodology from Colaizzi (1978). Methodological rigor was essential to ensure the believability of information collected and was achieved by adhering to the trustworthiness criteria outlined by Lincoln and Guba (1985). The three patterns that emerged during the study were Opening the Door, Stepping Through, and Keeping the Door Open. Under the pattern of Opening the Door were the themes of Being in a Caring Group and Self Disclosing. Under the pattern of Stepping Through were the themes of Acknowledging Me as a Person and Giving. Under the pattern of Keeping the Door Open were the themes of Respecting, Sharing, Supporting, and Connecting. Findings relate to the theory of Nursing as Caring (Boykin & Schoenhofer, 2001) and offer insight into the relationships between nursing educators and nursing students, and increase understanding of the reciprocal nature of caring. Additional research is needed to more fully explore caring relationships in nursing education.

Interprofessional Education: Embracing the Difference Caring Makes in Nursing Education and Practice
Gail B. Williams, PhD, RN, PMHCNS-BC; Mark D. Soucy, PhD, RN, PMHCNS-BC, FPMHNP-BC; Maureen Rubin, PhD, University of Texas Health Science Center at San Antonio School of Nursing, University of Texas at San Antonio, San Antonio, TX, USA

Background: The Institute of Medicine’s consensus report, The Future of Nursing: Leading Change, Advancing Health, (2010), calls for transformation in nursing education to prepare nurses to practice to the full extent of their education and training. Accordingly, nurses should participate as full partners with physicians and other health care professionals in redesigning health care in the United States, and effectively promote policy based on the collection and analysis of data in an evolving information infrastructure. A critical pathway to this transformation is the development and integration of curricular strategies leading to competencies in four domains of interprofessional practice: values/ethics for interprofessional practice, role and responsibility, interprofessional communication and teams, and team work.

Discussion: This presentation will describe the development and implementation of a novel interprofessional educational model in the context of community psychiatry where learners from nursing, medicine, social work, and psychology come together in an interprofessional team based care model addressing the needs of a severely underserved, economically disadvantaged population with complex mental health problems.

Findings and Implications: Preliminary findings will address how students and faculty learn from one another as they develop the knowledge and skills to practice collaboratively. Strategies for identifying and overcoming barriers to interprofessional education will be described. Together as a team, caring can be expressed in a holistic manner to support the needs of those that are not mainstreamed into the typical health care system.

Spouse Caregiving Viewed through the Lens of Watson’s Theory of Human Caring
Christine L. Williams, RN, DNSc, PMHCNS-BC, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

Most literature on caring concerns nurses’ caring relationships with patients. This study focuses on caring relationships in marriage when a spouse is living with Alzheimer’s disease. Over 4.5 million Americans are affected by Alzheimer’s disease and 5 million caregivers take responsibility for their care. Spouses make up the majority of these caregivers. As Alzheimer’s disease progresses, language problems such as finding the right word, repeating the same word or question over and over, and substituting one word for another become frustrating. Loneliness and loss can replace affection and intimacy for spouse caregivers and partners.

Problem: Communication breakdown between persons with Alzheimer’s disease and their spouse caregivers contributes to marital estrangement. Little is known about caregivers efforts to maintain this intimate relationship. The purpose of this study was to discover the communication processes that spouses use to sustain loving kindness, hope, connection, meaning, trust, empathy, and engagement in relationship with a loved one.
**Purpose:** To describe caregivers’ ways of caring in conversations with a marital partner affected by Alzheimer’s disease and to discuss the role of nursing in supporting couples.

**Method:** Fifteen couples over the age of 55 who were living in the community with their spouses participated in the study. One member of the dyad attended a day program for memory disorders. Qualitative methods were used to uncover marital communication patterns. Couples were asked to engage in conversation for 10 minutes on a topic of their choice while the researcher left the room. Conversations were video recorded. All video recordings were later viewed repeatedly until patterns were recognized and described. The researcher viewed the videotapes again to refine and confirm patterns.

**Results:** The mean age was 77 for caregivers and 80 for spouses. On average, both partners were well educated (some college) and had been married over 40 years. While caregivers’ memory was intact, spouses evidenced moderate cognitive impairment. Caregivers reported that they had performed the role of caregiver for an average of four years.

Caring Patterns: Both verbal and nonverbal patterns emerged from the data illuminating ways that spouses preserved caring relationships. For example, hope was exemplified by a verbal pattern of “telling a story with faith” in which caregivers conversed with a spouse while receiving minimal feedback. Their efforts conveyed the belief that engagement was valued by both partners. Maintaining connection was evidenced in a pattern of nonverbal “expectant waiting” in which the caregivers quietly attended to a spouse who was silent or struggled to find the words to participate in a conversation. “News and weather” was a pattern commonly observed in caregivers expressing loving kindness by describing the schedule for the day, the weather, and news about the lives of close friends and relatives.

**Implications for Nurses:** Living with AD can be a lonely and frightening experience. Sustaining relationships with significant others remains as important for the person with AD as with any other person. Nurses have the opportunity to support caregivers as they struggle to find ways to connect with a loved one who seems to be drifting out of reach. Coming to understand patterns of relating that maintain caring relationships will help nurses to provide effective support for caregivers affected by the challenges of Alzheimer’s disease.

**Embracing the Difference Caring Makes:** Implementing Caring Groups in a New Graduate Orientation Program

Carol B. Wilson, PhD, RN, University of West Georgia, Carrollton, GA, USA; Carolyn M. “Kenzie” Martin, MSN, RN-BC, Atlanta, GA, USA; Janice L Esposito, MS, BSN, RNC-OB, C-EFM, Kennesaw, GA, USA

**Introduction:** Caring Groups have been an essential component of the undergraduate curriculum in the School of Nursing (SON) at the University of West Georgia (UWG) for almost 20 years. To continue the caring philosophy, UWG’s graduate program includes a one-hour course providing the opportunity to explore caring from a theoretical and personal perspective. As a result of participating in a course on caring, one of the MSN graduates of UWG’s program, responsible for orientation of new graduates, implemented Caring Groups as a component of their orientation within a large healthcare system.

**Purpose:** This presentation will describe the results of a qualitative study of caring groups in an orientation program for newly licensed nurses, based on the UWG model. Participants were asked to share stories of their participation in Caring Groups and their experiences during the first year of practice. Data will be provided that Caring Groups for new/novice nurses have a positive effect on the nurse’s experience of the first year of practice.

**Method:** An interpretive phenomenological study of newly licensed RNs hired within a large healthcare system who participated in caring groups as a component of their orientation was conducted. Transcripts of audio-recorded individual and focus group interviews were analyzed to describe a shared understanding of the meaning of the experience.

**Findings:** The stories of newly licensed nurses who participated in Caring Groups during their orientation reveal a common story identified in the following patterns: “Running uphill” But Not Alone, Gaining Perspective from the Top of the Hill, and Transformation: On the Downhill Side. At first, participants described the feeling that learning to be a nurse and learning about the institution felt as if they were “running uphill.” However they learned through Caring Group that they were not alone, which was helpful. As their first year progressed, participants indicated they began to gain some perspective, from the top of the hill. There was a common story about learning not to feel bad about not being perfect and to “not beat yourself up”. Transformation occurred through having support and collegial caring by knowing “you will always have someone to turn to.”

**Discussion:** Incorporating caring groups into nurse internship programs for newly licensed nurses has the potential to create a positive first year experience and may enhance the quality of care provided by novice nurses. Further research is needed to determine the efficacy of caring groups in providing support as novice nurses move toward achievement of expert nursing practice.

**Making a Difference in Graduate Education:** Implementing Online Caring Groups

Carol B. Wilson, PhD, RN, University of West Georgia, Carrollton, GA, USA

**Introduction:** Since the curriculum revolution of the late 1980s, nursing education programs have integrated the
theory and practice of caring science into curricula in a manner that values caring and models it for others. In 1992, the University of West Georgia's (UWG) Department of Nursing faculty embraced the philosophy guiding a caring curriculum in the undergraduate program. The cornerstone of this curriculum provides the opportunity for students to participate in Caring Groups as an experiential teaching-learning strategy to facilitate the learning of caring. With the addition of a Master of Science in Nursing (MSN) program, a course on caring was included in the curriculum, although the Caring Group concept was not followed through in the program. In 2012 the EdD in Nursing program was also added. During the development of the EdD program, the faculty had a strong commitment to incorporate the 20+ year history of a philosophy of caring in the undergraduate program into the graduate programs. This creates consistency with the caring philosophy of the newly designated School of Nursing. Implementing Caring Groups in predominantly online classes presented challenges, since courses in the MSN program are greater than 50% online, and 100% online in the EdD program.

**Purpose:** This presentation will describe the implementation of caring groups throughout the predominantly online MSN and EdD graduate programs at the UWG. Creative strategies implemented to provide the opportunity for students to participate in virtual caring groups will be shared. These strategies have incorporated literature related to teaching online within a caring framework, as well as data from studies of caring groups at UWG. Findings from these studies will be related to development and implementation of online caring groups. While this is new territory for the School of Nursing at UWG, the faculty is committed to implementing caring groups throughout all programs.

**Discussion:** Opportunity for discussion of the potential for creating caring communities in nursing education via online Caring Groups will be provided. Participants in the conference will be encouraged to share any related experiences of creating an online caring learning environment.

**Using Caring Science to Design a Healing Environment for Radial Cath Recovery**
Megan Wilson, MSN, RN, BA, Formerly Presbyterian Hospital Matthews, Matthews, NC, USA

The medical approach to performing a cardiac catheterization is changing from access using the femoral artery to introduction of the catheter through the radial artery. This technique radically changes patient recovery, as patients can sit up immediately following the procedure, safe mobilization is possible almost immediately post procedure, and patients may be able to recover in their street clothes. In response to these medical innovations, nursing care and the healing environment was reframed using Watson’s caring science (2008) to enhance these and other patient outcomes and to improve nursing quality indicators for patients undergoing a transradial catheterization and recovery. The development and design of a radial lounge or Cath Café, as well as the adjoining cardiac triage unit, was undertaken using a theory-guided nursing approach to create a holistic caring-healing environment. The physical environment of the unit, staff development, and policy and procedure development were intentionally co-created using transpersonal caring as the philosophical foundation for nursing care delivery. Combining the concepts of Watson's theory of transpersonal caring with a more optimum physical environment within a nursing unit dedicated to optimum healing for patients undergoing transradial heart catheterizations was believed to promote better clinical outcomes, as well as improved patient and staff satisfaction.

Watson’s Ten Caritas Processes™ (CP) education focused on a deeper level of caring, consciousness, and being. The Caritas Nurse is one who is wholly committed to each moment, to evolve self, to promote a loving, kind and spiritual environment totally dedicated to healing and wholeness. While it was the intention of the authors to incorporate all caritas processes into the development of the new Cath Café and adjoining Cardiac Triage Unit, three were believed to be particularly significant in their effect on patient and nursing outcomes on the new unit. These concepts involved building trust (CP #4), teaching and learning through inner subjective meaning (CP #7), and creating a healing environment (CP #8). This presentation will discuss the interdisciplinary process of designing a unit guided by nursing theory.

**Finding the Light From Within**
Debra Wolf, MSN, ARNP, BC; Iris Lawrence, BS, RN, CCRN, Winter Haven Hospital, Winter Haven, FL, USA

**Introduction:** Demands on nurses and nursing are great, causing stress and depletion of spirit; therefore, it becomes paramount for nurses and nursing to engage in Loving-Kindness and Equanimity to Self™, to take time to center, honor, celebrate and reflect on all that they do so that they may rekindle their internal light and set it ablaze.

**Significance:** The professional practice model used at Winter Haven Hospital is based on Dr. Jean Watson's Theory of Human Caring and caring science (Watson, 2008). In order for the Theory of Human Caring to be operational, the theory must be cultivated into practice by the nurses at the bedside through teaching not only the Caritas Processes™/philosophy but additionally through teaching caritas literacy therein giving nurses language to express the quintessence of what they do every day “…developing how to Be while doing the real work of the job” (Watson, 2008, 47). Nurses’ perceptions of not being able to ‘give the care’ they think their patients deserve
leads to frustration and burnout. The project/intervention Finding the Light from Within is designed to help nurses to honor and celebrate their divine work and practice healing and renewal of self.

**Purpose:** The purpose of this project was to improve the Critical Care staff’s capacity to minister to their patients with Loving-Kindness™ by providing the weary Critical Care nurses with the renewing and spiritual experience of a Caritas Consortium (Watson, 2008).

**Setting and Participants:** Twenty-two RN participants came from the four Intensive Care Units (SICU, MICU, CICU and CVICU) and the CV step-unit. 2 Secretaries attended as guests.

The setting was a quiet conference room on the main campus of the hospital. The room was set up to replicate Dr. Watson’s Caritas Consortium (CC) with chairs arranged in a circle, candle light and an energy scarf with symbolic items placed upon the scarf. Homemade muffins, fresh fruit, coffee and juice were provided for the comfort of the participants.

**Project Description/Process:** The project was structured as a research study with the participants taking surveys prior to the interventions and then surveys one week and one month after the intervention. This project consisted of two 2-hour sessions patterned after Dr. Jean Watson’s ICCs providing nurses at this organization with the opportunity to experience an ICC in order to understand Caritas on a deeper, more spiritual, authentic, humanistic and sophisticated level.

**Project Outcome(s)/Projected Outcomes:** There was no statistically significance difference between the three surveys; however, when the items were rank ordered there was improvement in Loving-Kindness™. Anecdotally, the project was well received by the staff.

**Caring Protocols and Programs: Elements and Patterns in Interventional and Correlational Research**

Zane Robinson Wolf, PhD, RN, FAAN; Denise Nagle Bailey, EdD, MEd, MSN, CSN, School of Nursing and Health Sciences, La Salle University, Philadelphia, PA, USA; Patricia A. Keeley, MSN, RN, OCN, Service Excellence, Fox Chase Cancer Center, Philadelphia, PA, USA

Acute care healthcare agencies continue to focus on the outcome of patient satisfaction with the hospitalization experience. Some advertise that they are organizations in which caring services are a priority, but few have directly linked the effect of a caring-focused program, protocol, or standards on the outcome of satisfaction for hospitalized, adult patients. Furthermore, the need to create caring interventions that can be tested and replicated is critical to document the effectiveness of nurse caring in the context of healthcare outcomes. A systematic review was conducted to identify the effect of nurse caring on the satisfaction of hospitalized, adult patients. This follow-up study seeks to identify critical elements in interventional studies focused on nurse caring as a potential basis for future investigations. It will determine elements and patterns in the interventions (program, protocol, or standards) in the 16 studies identified in the systematic review with the purpose of isolating patterns, elements, and lessons learned explicit and implicit in this literature. Next, instruments that measure nurse caring will also be analyzed for patterns and elements indicative of caring behaviors or activities that represent nurse caring and that could contribute to a nurse caring intervention. Content analysis will be used to identify patterns and themes that evidence elements of caring interventions in the 16 studies specified in the systematic review and instruments published in the following citation: Watson, J. (2009). Assessing and measuring caring in nursing and health sciences (2nd ed.). New York, NY: Springer. The investigators will independently conduct the analysis and compare themes and patterns. The findings of the analysis will be compared to structures discussed Sidani and Braden’s (2011) book on nursing interventions. For example, intervention theory, construction of a list of intervention strategies, algorithm creation, strategies to enhance intervention implementation, training interventionists, intervention fidelity, phases for intervention evaluations, and feasibility and efficacy of interventions will be used to expand the analysis as a triangulation method.

**Breaking the Cycle of Incivility: Invitational Interactions and Caring Behaviors within Nursing Education**

Terri P. Worthy, MSN, RN; Sharon Grason, MS, RN, Mercer University, PhD Nursing Program, Atlanta, GA, USA

Educating nursing students and advancing a new generation of passionate, caring, and competent nurses are primary goals of nursing education. However, the increased demands on nursing faculty and the complexity of the profession can promote an environment of incivility. Unfortunately, over the past 15 years, there have been multiple news reports of incidents of lethal force shown by disgruntled individuals in various educational settings. These attacks have been carried out against students, faculty, and administrators. Although these incidences are extreme forms of incivility, the reporting rate at which mild to moderate levels of uncivil behavior has been perceived to be on the rise. In response to this increase, incivility in nursing education has been studied for the past decade in order to increase the body of knowledge on this topic. Researchers are making strides in compiling rigorous quantitative and qualitative studies to gain better insight regarding the faculty and student experiences with uncivility. One specific question remains, how can faculty achieve program educational goals if nursing students experience incivility and bear witness to such behaviors as acceptable and commonplace in the nursing profession? Nursing professionals today endure multiple demands in clinical settings, which provide ample
opportunities for increasingly stressful situations. Unfortunately, such stressful occurrences can lead to uncivil behaviors and promote negative interactions between faculty and students. Uncivil behaviors and uninviting interactions can intimidate, demean, and discourage the recipients. Nursing students will often suffer in silence, emotionally withdraw, and attempt to avoid future interactions with the offending instructor after an uncivil encounter. Nursing faculty may also withdraw and potentially dislike teaching and decide to leave nursing education practice. Even more concerning is the potential for nursing students to believe this is a normal experience within the nursing profession and they continue to endure, or worse, promote incivility and workplace abuse. As a community of educators, we must not only condemn uncivil and abusive behaviors, but in fact, raise awareness through open dialogue, counteract the problem through application of inviting interactions, and actively engage in promoting a caring learning community. This poster presentation will discuss current literature regarding incivility within nursing education, introduce invitational education and human caring concepts, demonstrate inviting communication, and provide creative instructional strategies to effectively break the incivility cycle.

Enhancing Care for Cardiac Patients with Diabetes through Telehealth: Development of a Cross Cultural Intervention

Chiung-Jung (Jo) Wu, RN, DrHlthSc, School of Nursing, Institute of Health and Biomedical Innovation (IHBI), Queensland University of Technology, Brisbane, Australia; Hui-Chuan (Christina) Sung, RN, PhD, Taiwan; Anne M Chang, RN, PhD, Tzu Chi College of Technology and Tzu Chi University, Taiwanese Evidence-based Health Care Center, Affiliate Center of JBI, Tzu Chi College of Technology, Hualien, Taiwan; Mary Courtney, RN, PhD, School of Nursing, Midwifery and Paramedicine, Faculty of Health Sciences, Australian Catholic University, Brisbane, Australia; Marilyn Ray, RN, PhD, CTN-A, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

**Background:** Evidence of positive health outcomes were found in our previous studies on self-management programs for cardiac patients and diabetes incorporating telehealth such as telephone and text-messaging (SMS). It is also important to consider the caring style (could revolve around communication spiritual-ethical caring) of transcultural communication, the patient/family members would feel, although not seeing the nurse, cared for. However, to compare international adoption of this program, the current English materials have been translated into Chinese for use in Taiwan. Also further investigation is needed on using inexpensive, user friendly Information Technology (IT) such as telephone and SMS to promote self-management programs for patients with two serious co-morbidities and address transitional care (from hospitals to home).

**Aim:** To develop and test a Cardiac-Diabetes Self-Management Program (CDSMP) incorporating telephone and text-messaging follow-up support for cardiac patients with diabetes in two different cultural contexts: Taiwan and Australia.

**Method:** A blocked randomized controlled trial is used to evaluate the effectiveness of the CDSMP. The main outcomes are self-care behavior, self-efficacy levels, knowledge, and quality of life in Australian (English-speaking) and Taiwanese (Chinese speaking) participants. The CDSMP consists of face-to-face sessions while the patient is in hospital, and is followed up by telephone contact (1 week post discharge) and two text-messaging reminders (weekly post telephone call).

**Conclusion:** Findings from this study will enable specific, targeted, educational intervention programs to address the needs of people with cardiac disease and diabetes. Also findings will provide implications for future development of the program in different cultural diversity. If using this strategy can achieve similar or better outcomes, this approach could potentially reduce demands on healthcare utilization.

**Acknowledgements:** This project is funded by Queensland University of Technology (QUT) Institute of Health and Biomedical Innovation Human Health and Wellbeing Collaborative Research Development grant.

**Posters**

**Studying the Physical and Psychological Symptoms of Patients with Cancer**
Aygul Akyuz; Memnun Seven; Nese Sever; Sefika Dincer, Gulhane Military Medical Academy, School of Nursing, Turkey

**Objectives:** The aim of the descriptive study was to evaluate the frequency and severity of physical and psychological symptoms so as to determine palliative care needs of cancer patients.

**Methods:** Total 142 patients who were treated in oncology clinic at a university hospital were enrolled in the cross sectional research. The Descriptive Information Questionnaire was developed by the authors and the adapted Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI), Edmonton Symptom Assessment System (ESAS) were used to collect data and evaluate psychological and physical symptoms.

**Results:** The mean age was 49.35 years and 54.9% of them were outpatients; 16.2% of the patients were diagnosed with colon and 13.4% breast cancer. The mean BDI score was 8.59±6.36, and 88.7% the patients have depressive symptoms. The mean BAI score was 11.39±7.53. The three most frequent problems were fatigue (87.3%), breathlessness (76.1%), and insomnia (67.6%). The mean of the highest-symptom was 8.59±6.36, and 88.7% the patients have depressive symptoms.
Is the Baby Pink? Changes in Neonatal Resuscitation
Loreli Bischoff, BSN, RNC-NIC, Providence Little Company of Mary Medical Center, Torrance, CA, USA

Problem: In previous editions of the Textbook of Neonatal Resuscitation, healthcare providers have been trained to ask themselves “Is the baby pink?” at 30 seconds of life. If not, they were trained to administer 100% oxygen to “pink up” the baby. New guidelines for neonatal resuscitation, published by the American Academy of Pediatrics/American Hospital Association, recommend beginning resuscitation with 21% oxygen (room air) and monitoring oxygen saturation. These guideline changes are based on evidence showing that the use of 100% oxygen can cause cardiac muscle and renal tissue damage (Vento, Sastre, Asensi & Vina, 2005). Neonatal Resuscitation Program changes were implemented January 1, 2012. The requirements for certification are bi-annual, but staff needed education to alert them to the practice changes immediately.

Purpose: 1) Educate all maternal and child health staff regarding changes in NRP; 2) Create and disseminate a self-learning module for nursing staff; 3) Post guidelines identifying acceptable oxygen saturation ranges during the first 10 minutes of life in all delivery rooms.

Process: A PowerPoint® presentation was created including; choosing appropriate oxygen concentration for a newborn in distress, identifying risk factors of administering 100% oxygen in the delivery room, and new SpO₂ guidelines in the first 5 to 10 minutes of life. The PowerPoint® was emailed to all staff, who then had 30 days to complete the post test at an 80% pass rate. PowerPoint® content was also presented at several staff meetings. A laminated card with the new oxygen saturation ranges is now hanging on every warmer as a reference tool.

Outcomes: By quickly learning and implementing the new guidelines patient safety has improved. The entire maternal child health staff has been educated regarding the use of supplemental oxygen in the delivery room. Staff feedback has been overwhelmingly positive. Due to the success of this project, this model of education is being used as a template for dissemination of other new practices and equipment.

Introduction: Traumatic Brain Injury (TBI) is the leading cause of hospitalization in patients greater than 65 years old. Suffering a TBI can be life changing for patients and patients’ families. The entire dynamic of a home can completely transform by one fall. Furthermore the majority of elderly patients diagnosed with TBI have preexisting co-morbidities that contribute to and complicate TBI. Healthy People 2020 proposed the goal of healthy aging and improved quality of life for elders. In order to achieve this goal with elderly TBI patients, it is necessary to understand the complexities of life before and after TBI. Often families and patients are forced to change their past life and embark on a new way of living. This abrupt change is always stressful and sometimes devastating. The caring nurse practitioner is well positioned to help patients and their families as they transition from TBI to healthy aging and optimal quality of life.

Theoretical Lens: The theories of Nursing as Caring and Transitions are proposed as an interwoven lens to guide nurse practitioners working with elderly TBI patients. The framework developed by Boykin and Schoenhofer implies that all persons are caring and continue to be caring from “moment to moment,” suggesting that continual caring is sustained as patients transition from a sudden unexpected event such as TBI. Meleis describes the interdependent properties of transition as awareness, engagement, change and difference, transition time span, and critical points and events. When merged with Boykin and Schoenhofer’s ideas, these properties describe a natural movement and shifting of caring processes that demand attention to promote quality living.

Application: Nurse practitioners who care for patients after TBI guided by the interwoven lens of caring and transitions will consider each property of transition as one infused with continual caring. For instance, the nurse is called to consider what “matters most” to the TBI patient as awareness, engagement and critical points are experienced. A nursing situation will be shared, addressing the interwoven caring-transitions lens applied by the nurse practitioner working with elderly TBI patients. Nurse practitioners are caring transition facilitators, tailoring care to the patients point in transition, with the understanding that each person and each family have unique ways of living with the changes demanded by TBI.

Implications: Nurse practitioners who have a framework that is grounded in caring and a belief that people are unique can act as caring transition facilitators for elderly patients with TBI. When viewing elderly TBI patients and their families through the caring-transitions lens, there is the best potential for achieving the Healthy People 2020 goal of healthy aging and quality living in spite of TBI.
The Humanistic Model of Care: A Driving Force for Nursing Education
Chantel M. Cara, PhD, RN, Nursing Sciences, Université de Montréal, in Québec, Canada, Center for Interdisciplinary Research in Rehabilitation (CIRIR), Quebec Nursing Intervention Research Network (RRISIQ), Québec, Canada.

The purpose of this poster presentation is to share a pragmatic Humanistic Model of Nursing Care (Girard & Cara, 2011; Cara, 2012) being implemented throughout the baccalaureate, master, and doctoral nursing programs at the Université de Montréal in Quebec, Canada. This poster highlights two major areas: (a) the model’s development (its historical context, mission, goals, humanistic values, and conceptual definitions), and (b) the model’s impact on nursing education (teaching methods, creating learning activities, evaluation).

This caring model serves as the framework for a competency academic based program focused on the apprenticeship of caring for patients, families, community, and populations. As teachers, who embrace a caring ontology, it is possible to transform our world view to empower students to facilitate their creative potential and to contribute to new knowledge development. Our objective is to encourage students’ reflective practice, subjectivity, and relation to the person/family/community’s perspective, which will promote their apprenticeship of a caring practice. Through openness, respect, nurturance, and support, teachers can invite students to gradually grasp and develop a pragmatic, conceptual, and scientific approach that will contribute to their understanding of caring as a moral imperative. Ultimately, as Hills and Watson (2011) mentioned, being informed by a caring ontology not only can assist teachers to transcend traditional pedagogy and teaching strategies, but can further enrich our discipline and promote nursing students’ co-creation of knowledge.

Identified Factors in the Socialization of the New Graduate Registered Nurse in the Intensive Care Unit to Promote Patient-Focused Care
Celestine Carter, APRN, DNS; Leanne Fowler, RN, CCRN, MSN; Gwendolyn Stewart-Woods, RN, MSN, Louisiana State University Health Sciences Center, School of Nursing, New Orleans, LA, USA

The presentation will describe challenges that technology in nursing care has presented to new graduate nurses orienting in a critical care unit. In the critical care arena, technology used in direct patient care such as ventilators, cardiac monitors, pacemakers, and ventricular assist devices can identify the patient, disguising his/her humanity. The challenge is to recognize the affects this has on the Preceptor’s ability to care for the patient and how Preceptors translate this to the new graduate RN orienting to the intensive care environment. This review of the literature identifies factors that help develop a sense of humanity and caring in the new graduate nurse, through the complexities of patient care in the intensive care environment.

Simplicity: Where Magic, Mystery, and Miracles Truly Begin
Ashlea Cook, RN, BScN, Alberta Children’s Hospital, Calgary, Alberta, Canada

For a pediatric patient, the world within a hospital can be one full of unknowns and frightening mysteries. Therefore, it is imperative that I, a pediatric nurse, incorporate magic into my practice to provide the child with the tools to navigate their uncertainties and to de-mystify the illness experience. The key to creating magic involves putting yourself in their shoes, remembering what it is like to be a child again; and always striving to remember that a child wants to be treated as a “kid” even when they are sick. However, to create magic you first have to develop a relationship which demonstrates to the child that you can be trusted. Through the magic of trust you can help a child and their family turn their fears into resiliency. Simplicity is what brings magic, mystery, and miracles into my practice. I believe you have to take the time and make the effort to consciously step back from the fancy diagnoses, medications, and procedures to remember that it is all about the simple actions. Caring for children is all about the ability to play and relate which are essential to providing influential care. These simple actions are a few of the stepping stones to making dreams come true and miracles happen.

Caring and Reflection in Cameroon
Holly Diesel, PhD, RN; Donna Taliaferro, PhD; RN, Patrick Ercole, PhD, MPH, Goldfarb School of Nursing at Barnes-Jewish College, Saint Louis, MO, USA

A group of four faculty and eight pre-licensure baccalaureate nursing students embarked upon a two week immersion and global service learning experience to Cameroon, West Africa. Global service learning offers a range of learning experiences and opportunities to develop skills that will be critical to successfully making the transition to practice in increasingly diverse populations in the US. Caring, as the essence of nursing, is a process of interaction and communication, and in that, is a reflection of nurses’ doing, being and knowing. Leininger has sought to identify the relationships between caring and cultural beliefs and practices. As part of the global service learning immersion, nursing students kept daily reflective journals to uncover their responses to various experiences. Reflective practice, whether written or lived, helps the practitioner, in this case the students, to access, understand and learn through their lived experiences. Through this process, the student can begin to make behavioral changes that move them towards a changed perspective and what is a more desirable practice. Reflective
practice, for the novice, needs to be guided, especially when
the situations that face student nurses in global settings are
unique to themselves and to nursing. Nurses make decisions
based on experience, and that requires that nurses also make
efforts to reflect on their experiences to understand what they
are doing and what they want to achieve. Reflection begins
with a description of the experience, from which the student
can then focus on key issues for reflection.

Developing an International Nursing Program Excursion
Holly Diesel, PhD, RN; Patrick Ercole, PhD, MPH; Donna
Taliaferro, PhD, RN, Goldfarb School of Nursing at Barnes
Jewish College, Saint Louis, MO, USA

Caring and compassion often provide the key impetus
for change and is often the motivator for why many nursing
programs have considered taking a group of students abroad.
Immersion gives students an opportunity to develop their
communicative and caring skills in addition to gaining real
insight into both a new culture and their own. Organizing
such a trip is a formidable task, but with adequate time and
thorough preparation, the experience will be successful and
enjoyable for all stakeholders. Background work is necessary
to identify the location and in-country support for any trip.
Recruitment is the opportunity to cast a wide net and
maximize the pool of potential student travelers. Depending
on the number of applicants, the selection process can be
one of the most time consuming and critical segments of the
process and potentially is the section that caring behaviors
are most needed. All team members, especially those new
to international travel will benefit from adequate preparation,
which should include local customs, culture, food,
transportation and accommodations at a bare minimum
to ensure that uncaring behaviors are not unintentionally
demonstrated. Each trip will be largely dependent upon the
make-up and relationships that emerge between the team
members. Setting ground rules for caring and resolving
conflict during the immersion experience is essential, as
virtual strangers in close quarters for extended time periods
is a recipe for discord if not managed early. Debriefing the
students upon return will produce an abundance of
information that will be instrumental in planning for
subsequent travels to promote international caring.

Is Caring Possible in a Virtual Learning Environment?
Holly Diesel, PhD, RN, Goldfarb School of Nursing at Barnes-
Jewish College, Saint Louis, MO, USA

In an environment with increasing demands for lifelong
learning and decreasing time and resources, alternative
forms of content delivery have been devised including virtual
learning environments (VLE). VLE is a set of teaching and
learning tools designed to enhance a student’s learning
experience by including computers and the internet.

Experiential learning occurs through critical relationships of
the learner to self, the learner to teacher, and the learner to
the environment. In order for the attitude of caring to become
internalized, students must feel valued and appreciated. This
may be difficult to achieve in an environment which physically
isolates the student. One the human side, students are
isolated from the teacher and their peers, which can result
in missing the happiness or joy of real world classes, and
the sharing and bonding experiences that take place in a
traditional college or university. Yet, there are ways to
ensure that the social interaction which is the basis for the
establishment of relationships necessary for caring to occur
can be achieved. This presentation will discuss approaches
that student and teacher alike may use to facilitate caring
relationships in a virtual world, where learning occurs through
synchronous, live chats or asynchronously where students
may also proceed at “self-paced” learning as the work is
completed. Advantages of a VLE include its flexibility,
opportunity for prompt feedback from the teacher and other
students, range of resources and collaboration with others.
The disadvantages of VLE include extensive time and skills
investment at inception as well as significant capital outlay
for equipment.

Now You See the Foley, Now You Don’t: The Magic of
Reducing Urinary Catheter Device Days and the Impact
on Urinary Tract Infection Rates in the Neuro-Surgical
Intensive Care
Marlienne Goldin, RN, BSN, MPA; Denise Wolfe, RN, CNRN,
Moses Cone Memorial Hospital, Greensboro, NC, USA

Purpose: Catheter-associated urinary tract infections
(CAUTIs) are the most common hospital acquired infections.
CAUTIs lead to an increased mortality, additional healthcare
costs and longer lengths of stay. A higher rate of CAUTI in a
Neuroscience Intensive Care Unit (NICU) may be due to their
patients’ neurogenic bladder dysfunction. Our NICU
collaborated on an evidenced-based project to decrease the
number of catheter device days as an intervention to
decrease our rate of CAUTIs.

Description: The NICU nurses reviewed the literature to
identify indications for urinary catheter use and evidenced-
based methods for insertion, maintenance and post-removal
care for indwelling urinary catheters (Elpern et al., 2009;
Fuchs et al. 2011). A focused search of the literature allowed
the staff to understand the truths of bladder dysfunction in
the neurologically impaired patient (Poisson et al 2010).
A surveillance tool was created to address indications for
continuance and incorporated a check-off of maintenance
care. After physician review and approval, the team took
responsibility for instructing the remainder of the NICU nurses
on the purpose and use of the tool. The tool was used during
hand-off communication between shifts to ensure urinary
catheter removal when indicated and adherence to evidence-
based urinary catheter care. Indicators for leaving catheters in place were strictly adhered to and post-removal care implemented to ensure adequate bladder functioning. Indications for leaving catheters in place were collected and used to modify the tool to clarify appropriate indications for maintaining the urinary catheter.

**Evaluation and Outcomes:** Implementation of our surveillance tool that ensured appropriate catheter discontinuation decreased the number of urinary catheter days from 2492 days to 1992 days, reflecting a 31.5% reduction over the previous 12 months. Urinary catheter utilization fell from 0.73 to 0.63, well below the National Healthcare Safety Network (NHSN) mean rate of 0.74 for NICUs. CAUTI rates also significantly declined from 4.82 to 2.51 NHSN rate of 4.0 for NICUs.

**Using the Magic of Caring to Reduce Ventilator Associated Pneumonia: Thinking Outside the Bundle**

Marlilene Goldin, RN, BSN, MPA; Devon Lofters, RN, BSN; Megan Powell, RN, BSN, Moses H. Cone Memorial Hospital, Greensboro, NC, USA

Ventilator-associated pneumonia (VAP) is a significant problem in trauma patients, increasing mortality and cost of care. While monitoring adherence to VAP prevention strategies reflected 98% compliance, our VAP rate revealed monthly variation (0 to 34) and a plateau for two consecutive years (8.04). Nurses in the Neuro ICU recognized the need to apply different strategies to impact trauma patients’ outcomes. We recognized the importance of an interdisciplinary team approach to decrease the incidence of VAP. Additional stakeholders were added to the team. We created a check off tool to be used during rounding. Modifications to the tool occurred frequently to improve communication during rounding. The Neuro ICU began using the tool to round every day on all ventilated patients while maintaining biweekly interdisciplinary rounding with the Trauma Services. Since implementation of intentional VAP rounding and daily use of the interdisciplinary tool, Trauma Services have experienced a zero VAP rate for six consecutive months. Implementing the same process on every ventilated patient, the Neuro ICU has decreased their overall VAP rate from 3.0 to 1.54 over the same period. Vigilance to ensure continued rounding and prompt implementation of interventions continues to be a strategy supported by leadership. Transpersonal caring workplace relationships resulted in mutual goal setting and improved communication. Collaboration and enhanced communication among health care providers resulted in better patient outcomes and created a culture of safety.

**Investigation of the Breast, Cervical, and Colorectal Cancer Screening Status of a Group of Turkish Women**

Gulten Guvenc; Memnum Seven; Ayse Kilic; Agyul Akyuz; Gulcin Akcan, Gulhane Military Medical Academy, Obstetrics and Gynecology Nursing, School of Nursing, Turkey

**Introduction:** The aim of the study was to determine the breast, cervical, and colorectal cancer screening rates and the influencing factors in a group of Turkish females.

**Methods:** The descriptive study was conducted in a school of nursing. The study sample consisted of 603 females who were the mothers/neighbors or relatives of the nursing students. Data collection forms were developed by the investigators after the relevant literature was screened and were used to collect the data.

**Results:** Of the women aged 30 and over, 32.8% had undergone a Pap smear test at least once in their life. Of the women aged 50 and over, 48.2% had undergone mammography at least once and FOBT had been performed in 12% of these women in their life. Having heard of the screening tests before, knowing why they are done, and having information on the national cancer screening program were important factors influencing the rates of women having these tests done.

**Discussion:** The results of this study show that the rates of women participating in national cervical, breast, and colorectal cancer screening programs are not at the desired levels. Having heard of the screening tests before, knowing why they are done, and having information on the national cancer screening program were important factors influencing the rates of women having these tests done. It is suggested that written and visual campaigns to promote the service should be used to educate a larger population, thus increasing the participation rate for cancer screening programs.

**HUSH©! A Nursing Culture Change to Create a Caring/Healing Environment**

Maricel B. Hinkulow, MSN, RN, CNL, OCN; Carlo Parker, PhD, RN; Donna H. Griffith, MSN, RN, NEA-BC, CENP, FACHE, FAAN; Sharon Kinane, MSN, RN, CNML, Martin Health Systems, Stuart, FL, USA

**Introduction/Purpose:** One of Florence Nightingale’s concerns was the effect of noise on patients as she wrote “Unnecessary noise is the most cruel absence of care which can be inflicted either on sick or well.” Noise in the acute care environment contributes to patient dissatisfaction and low Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, an accepted indicator of quality care. HUSH© (Hospital’s Ultimate Silence for Healing©), a noise reduction program, was developed in collaboration with nurses at all levels of practice and hospital administration with the intent of changing nursing culture by creating a caring/healing environment conducive to recuperation. The
The purpose of this nursing research study was to investigate the culture change by assessing patient satisfaction and nurses’ perception of the HUSH© program.

**Methodology:** A two-phase descriptive study was undertaken. In Phase One, the hospital’s 2010-2012 HCAHPS scores, pre- HUSH© and during HUSH©, were analyzed. Subjects in Phase One were two cohorts (12 pre-HUSH© and 12 during-HUSH©) on an oncology unit. A semi-structured interview was conducted in Phase Two during-HUSH©. Nurses’ evaluations of HUSH© were queried with another semi-structured interview. Descriptive statistics were used to analyze HCAHPS scores and an inductive approach to content analysis was used to synthesize data.

**Results:** In Phase One, randomized hospital-wide responses to the HCAHPS question about the percent of patients who “always” reported quiet around their room at night was 39%-84% pre- HUSH© and 48%-58% during-HUSH©, while the Oncology unit responses were 17%- 65% pre-HUSH© and 0%-61% during-HUSH©. Responses to the during-HUSH© interview question: “During this hospital stay, how often was the area around your room quiet at night?” were: Never, 0%; Sometimes, 33% (4); Usually, 33% (4); Always, 33% (4). In spite of low HCAHPS scores, the majority of patients noted quiet as “Always” and “Usually” during-HUSH© (66%) which represent patients perceived change in their environment. In addition, content analysis of Phase Two data indicated that nurses were appreciative of HUSH©, with comments like: “it brings calmness to the afternoon and night,” “I can finally catch up and regroup,” “fewer call lights are going off during HUSH© time,” and “this is the best change I’ve seen in this hospital for the last 25 years.” Patients also expressed appreciation of staff efforts to reduce noise by implementing “HUSH© Time,” closing doors, turning off lights, and talking softly especially during night shift.

**Discussion:** The HCAHPS scores remained below Center for Medicare & Medicaid Services (CMS) percentile during the HUSH© program, but this may not reflect the “true” impact of HUSH©. Interview results indicate a positive reaction to a quieter environment created by HUSH© which was favorably received by staff and patients, leading to a question about the necessity of an “always” quiet environment to determine patient satisfaction. Moreover, HUSH© program indicates a potential change in the nursing culture that which embraces a caring/healing in the acute care environment. The prevalence of quietness perceived by patients and nurses has led to a mutual respite for both. Commitment of each hospital staff member and administration is essential to anchor a culture shift to a caring/healing environment through HUSH©.

Recently, the success of HUSH© has led to its hospital-wide implementation which promises to extend the culture change throughout the system.

**Implementation of Hoshashi’s Family Care/Caring Theory (FCCT) in Concentric Sphere Family Environment Theory (CSFET)**

Naohiro Hohashi, PhD, RN, PHN, LSN; Junko Honda, MS, RN, PHN, LSN, Kobe University Graduate School of Health Sciences, Hyogo, Japan

Hoshashi’s Concentric Sphere Family Environment Theory (CSFET) is a family nursing theory that focuses on the family environment that acts on the well-being of the family system unit (Hohashi & Honda, 2011). The family environment takes the form of a three-dimensional logical space-time continuum formed by three assessment axes of relationship (structural distance, functional distance, and temporal distance), in which five systems (supra system, macro system, micro system, family internal environment system, and chrono system) are located. This enables a three-dimensional view of the entire family system unit. In Ver. 2.4 of the CSFET, Hoshashi’s Family Care/Caring Theory (FCCT) is implemented and a new assessment item, i.e., family health care nurses and their collaborators, is introduced in the macro system, and its rigor was established through a literature review, ethnographic studies, and semistructured interviews with 21 Japanese families living in Japan and eight Japanese families in Hong Kong in the three years of 2010, 2011 and 2012. In the FCCT, “family care” is defined as a practice directed toward supporting the maintenance and improvement of the family functioning of the target family, while “family caring” is defined as attitudes toward realization of effective family care by knowing the beliefs, intentions, and hopes of the target family. Family caring is the concept that serves as a basis for engagement with the family system unit in its entirety, and is needed for providing family support that focuses on non-invasive treatment methods. Thus, family caring is positioned in between the CSFET and family support. By this, the relationship of trust between the family and the nursing professional can be clearly established in terms of the structural distance and functional distance of the CSFET. Furthermore, it is evident that it will be also necessary to highlight the concept of time, i.e., the temporal distance of the CSFET, when considering how to structure the relationship between the family and the nursing professional in terms of a given time and place, as well as within the passage of time.

**Testing and Verifying Nurses Caring Behavior Assessment (NCBA) by Confirmatory Factor Analysis**

Tzu-chuan Hsu, RN, MSN, Director of Nursing; Jane Lee-Hsieh, RN, MSN, Professor; Su-Fen Cheng, RN, PhD; Michael A. Turton, MA, Taiwan Adventist Hospital, Taiwan

**Background:** To enhance the quality of nursing care, a hospital in northern Taiwan committed to implementing its SHARE (“S: Sense people’s needs before they ask,” “H: Help each other out” “A: Acknowledge people’s feelings,”
“R: Respect the dignity and privacy of others,” “E: Explain what’s happening”) framework in clinical practice. However, the SHARE idea was poorly defined, lacking both content and performance indicators.

Objectives: The aim of this study was to validate the SHARE five domains of Nurses Caring Behavior Assessment (NCBA) using confirmatory factor analysis.

Methods: This study was conducted in 3 phases. In Phase 1, based on our previous Caring Behavior Measurement developed from the patient perspective via an exploratory factor analysis (EFA) in Taiwan (Lee-Hsieh, et al 2005), the researchers developed a 29-items NCBA to measure nurse caring behavior from the patients’ perspective. In Phase 2, a convenience sample of 305 hospitalized patients from this hospital was recruited to test the construct validity of the NCBA. Finally, in Phase 3 the internal consistency reliability of the instrument were tested.

Results: This 29-items NCBA across the five domains of SHARE. The final model in confirmatory factor analysis revealed that the NCBI indicated a good fit of the model (GFI = 0.87). The value of Cronbach’s alpha for the total scale was 0.88.

Conclusions: The NCBA is a valid and reliable instrument for assessing nurses’ caring behaviors. The instrument enables descriptions of the content of SHARE based on the nurse-patient interaction. It may also enable nurse administrators to assess the quality of nursing care and design continuing education programs that promote quality care at the hospital.

Caring Practice of a Psychiatric Nurse in Japan Analyzing from Caring Theory Focusing on the Inner Process of the Individual

Junko Ishikawa, RN, MSc; Masashi Kawano RN, CNS, MN, Jikei University School of Nursing, Tokyo, Japan

Aim: The aim of study was at demonstrating what kind of elements in caring practices are influenced by the personal life history of the psychiatric nurse in Japan.

Design and Method: Interviewee; A psychiatric nurse, a female in her late fifties with about 40 years of working experience as a nurse (17 years in psychiatric nursing).

Data Collection: We conducted two semi-constitutive interviews, each about 90 minutes long, in a room prepared by a psychiatric hospital. We asked a nurse to tell the episodes and experiences she went through in her life, and then to talk freely about her influences on her job and the scenes impressive to her. We recorded the interviews and created a verbatim report.

Analysis: A qualitative descriptive research design consulting the Life-History Method. We aligned the data per event and sorted out the “episodes” that affected the nurse’s caring practice and her “feelings at the time.” After member checking, we analyzed and interpreted what elements of caring practice are influenced by the subjective experiences of a nurse. We worked on analysis between researchers repeatedly to raise reliability and validity. In addition, we are employing Jean Watson’s Caring Theory as the background of the research.

Discussion: Having grown up without experiencing her parents’ affection and thus been eager for love, the nurse turned herself strong and independent, and learned to offer unconditional love to others. Also, her encounter with her great teacher who had led her into nursing formed her “passion” for it in the way that she works hard in the nursing profession as a return for the affection she received from her teacher. We considered this as Watson’s “caritas consciousness.” Furthermore, it was implied that a nurse had learned the means to deal with others with sincerity and honesty due to her childhood experiences with so many hardships that all she could do as a child was just to survive every day. We can possibly say that later they blossomed into a nurse’s “challenging spirit to herself.” Moreover, we deduced that her experiences of suicidal attempts and getting help from a delinquent student generated her “sincere face”: her attitude of facing intimidating patients at her own risk rather than holding herself back.

Conclusion: We learned that the life history of a nurse has had a great influence on her caring practice. This indicates that reflecting on her individual life history helps nurses to rediscover her own unique ways of practicing patient care.

Practice of Nursing Counseling to a Chronic Person with Schizophrenia Living in Community in Japan – Application of Watson’s Caring Theory

Aim: In Japan, there is a nurse (male, Mr. M) who is practicing nursing by counseling persons with mental disabilities in the community. This is regarded as a very rare case. He learned the theory of Watson’s Human Caring in Colorado and is applying it to his counseling practice. We hereafter report this case after having analyzed one of nursing scenes as Mr. M counseled a patient based on caring theory.

Design and Method: Data collection – The objective of the analysis is a scene when the nurse was counseling a patient on a certain day. Mr. K lives in his home and is suffering from chronic schizophrenia. The purpose of the counseling was intended to have Mr. K actually realize real life. His symptoms triggered his behavioral transformation in daily life.

Analysis: Researchers recorded the scene of the nurse counseling the patient frequently. They carried out the study by matching the 10 caring elements with the caring scenes that observers recorded.
Result: Many findings were described. For example, "#10: Even though the nurse carried out counseling Mr. K for 5 years, he remained open to the position that there was still something that he does not know about Mr. K." The soul and mystery of the nurse, as well as his open mind, was revealed. The first impression of the nurse counseling scene was that both sides (nurse and Mr. K) were laughing a little and gently. Mr. K once mentioned to the nurse that "You look unnatural" which seemed to represent a kind of negative attitude while he was still laughing a little. The researchers watched the scene and felt relaxed. The counseling atmosphere was comfortable and nice.

Discussion: Watson’s caring theory was applied to many caring elements. In Japan, approximately 70,000 people suffering chronic schizophrenia are being hospitalized and unable to leave the hospital. We think that if the practice of nursing through counseling becomes more popular, then people suffering chronic schizophrenia might also be able to live in the community. This application of Watson’s caring theory might be helpful in this regard.

Ethical Problems Encountered by Nurses in Turkey
Emine Iyigun, RN, PhD; Sevinc Tastan, RN, PhD; Hatice Ayhan, RN, PhD; Halise Coskun, RN, PhD; Meral Demiralp, RN, PhD, Gulhane Military Medical Academy, School of Nursing, Ankara, Turkey

Objectives: The purpose of the study is to define the ethical problems nurses in Turkey encounter.

Methods: One hundred seventy-one nurses, who are working in Military Hospital, participated in the study. The researchers conducted a descriptive study and administered a questionnaire to collect data. The questionnaire was developed by the researchers and was based on a literature review. Questionnaires were filled out by nurses who agreed to participate in the study.

Results: Most of the nurses participating in the study stated that they realized that they were facing ethical problems when conflicts appeared regarding patients’ requests. The majority of nurses indicated that the greatest ethical problem was the priority of using resources. Organ donation was shown as the least encountered ethical problem when conflicts appeared regarding patients’ requests. The majority of nurses stated that they realized that they were facing ethical problems when conflicts appeared regarding patients’ requests. The priority of using resources was the greatest ethical problem (75.27%) and as colleagues (65.2%).

Discussion: The ethical problems nurses encounter during practice that are identified will guide which problems to select for nurses’ training and practice.
flow of positive energy throughout the organization expands our caring consciousness and transcends conventional outcomes.

**Qualitative Evaluation:** 400 participants have participated in this caritas journey so far. Their responses have been largely positive and inspiring. Please see the following results:

**Qualitative Response to Caritas Experience:**

**Non-Verbal Responses**
- Eyes closed
- Hugs
- Smiles
- Relaxed shoulders
- Tense stiff hands to relaxed hands
- Tears
- Glassy eyes
- Chills
- Quiet
- Crying
- Reached out to grab my hands and hold them
- Happy laughter
- Nervous laughter
- Warm hands
- Immediately read their chocolate message

**Verbal Responses**
- How synergistic!
- That was wonderful.
- Thank you for not leaving me and hunting me down.
- I’m ready to fall asleep.
- That was so relaxing.
- I need to take time out for myself.
- I need to think about caring for me more.
- You are like a Fairy Godmother.
- Do you get the chills each time you do this?
- This was great.
- This is a wonderful project.
- I can now see my next patient calmly.
- Tears, Smiles, Hugs…we did it all!
- This was very needed.
- Our staff deserves this support.
- I’m not a lamb to slaughter; this was like green pastures.
- Often we are victims of each other. Today I will not be a victim…I will be positive.
- This is beautiful.
- Can you tell my heart is racing?
- This is cool.
- It is so important to take care of yourself.
- I’m just a tech, I didn’t think this was for me.
- I’m not into all the foo-foo stuff. You are talking to someone who does take care of themselves.
- This only took 3 minutes? I can do this… I can take 3 minutes for myself.
- More, More, More!
- I could go longer.
- We would like to have you back!
- I lived through this.
- This wasn’t so bad.
- This is very touching that you would think of us.
- You really have taught me something.
- You are so kind.
- You are so sweet.
- Taking time out for yourself is very true.
- You caught me on a bad day, this is just what I needed.
- I need to take better care of myself.
- We do for others, it is so nice for someone to do for us.
- Your voice is so relaxing.
- You are very effective.
- You are very soothing.
- I wish you well in your journey.
- We need to all know we are important.
- I wish you luck in your travels.
- I appreciate you stealing 3 minutes of my day.
- I had to learn to let go and I have.
- You are just the right person for this.
- You truly don’t get the understanding of Jean Watson’s Theory until you experience it.
- Yes, it is your experience that makes you “get it.”
- Thank you.

**Other Responses**
- Just talked for 5 minutes without the hand massage
- Spoke of their family experiences
- Spoke of their continued caring for others beyond work
- Shared personal experiences, health, stress, etc...
- Shared their personal losses
- Reluctant to take a break due to task at hand
- Needed reassurance that they had permission to take the break

**End-of-Life Care in the Inpatient Rehabilitation Setting:**

**A Journey of Caring and Compassion**

Karyn A. Kling, BSN, RN, CRRN, Moss Rehab Hospital, Elkins Park, PA, USA

The inpatient rehabilitation environment is constantly evolving. Over recent years, there has been an increase in patient acuity due to patients with more complex medical conditions being admitted for acute-level therapy. At Moss Rehab Elkins Park, the 28-bed Brain Injury Rehabilitation Unit provides care primarily for individuals who have sustained a traumatic brain injury as a result of injuries sustained from assaults, falls, or car accidents. Occasionally, patients who have an acquired brain injury as a result of anoxia, meningitis, or brain tumors are admitted to the unit. Rehabilitation registered nurses work in collaboration with the entire
ranging their ambiguous identities and wondering whether
may result in caregiver strain and fatigue leaving these NMs
the caregiving expectations and demands of being a nurse
demands of caring for a chronically ill child superimposed on
an impact on their professional caregiving. The constant
accessing their nursing knowledge and expertise in the care
may find themselves consciously and unconsciously
with a chronic illness but may also caring for patients in their
physical caregiving demands of not only caring for a child
nurses, they are burdened by the added psychological and
their homes. While many parents may share the responsibility
of providing end-of-life care for a patient and the ethical and
caring situations encountered by the registered nurses and
treatment team. Watson’s Theory of Human Caring provides
a theoretical framework for registered nurses caring for all
patients and is especially relevant when interacting with dying
patients and their families. Honoring the patient’s wishes
and values, relieving pain and suffering, and enhancing the
patient’s current quality of life were the focus of care this
patient. As a unit, we recognized that caring for this patient
was truly a gift that allowed us to grow in caring and
compassion as Caritas Nurses. As we reflected on the
experience, the following quote from Dr. Jean Watson best
described the practice of nursing we had with this patient and
family. “On this life journey, we all come face to face with
mysteries and unknowns, and we are all challenged to find
our way” (Jean Watson).

How Nurse-Mothers of Children with Chronic Illness
Manage Their Compounded Caregiving Roles
Cheryl L. Leksan, PhD(c), RN, CNL, University of Cincinnati
College of Nursing, Cincinnati, OH, USA

Caring for a child with a chronic illness can present
parents with significant emotional and physical challenges/stressors. Given that there are over 14 million
children in the United States identified as having a chronic
health problem more parents are facing increasingly complex
caregiving responsibilities. With the advancements in
technology, more of these children are being cared for in
their homes. While many parents may share the responsibility
of caring for these children, it is most frequently the mothers
who fulfill the primary caregiver role. When these mothers are
nurses, they are burdened by the added psychological and
physical caregiving demands of not only caring for a child
with a chronic illness but may also caring for patients in their
professional caregiving role. These nurse-mothers (NMs)
may find themselves consciously and unconsciously
accessing their nursing knowledge and expertise in the care
of their children. Conversely, these women may find their
experiences in caring for their chronically ill children have
an impact on their professional caregiving. The constant
demands of caring for a chronically ill child superimposed on
the caregiving expectations and demands of being a nurse
may result in caregiver strain and fatigue leaving these NMs
redefining their ambiguous identities and wondering whether
they are mothers or nurses. The purpose of this grounded
theory study is to develop a theoretical framework that
describes how nurse-mothers of children with chronic illness
manage their compounded roles as both professional
caregivers and mothers of chronically ill children.

Research has identified a significant number of potential
negative health outcomes experienced by family caregivers,
particularly mothers of children with chronic illness. These
outcomes may include psychological symptoms such as
depression, fatigue and burnout. While fulfilling multiple roles
is a common task to most people, being a caregiver in both
a professional capacity and as a mother to a child with a
chronic illness is likely to result in the NM experiencing an
increased demand for emotional energy and caregiving
behaviors which may exceed her reserves and may result in
leaving the workforce. However, whether or not this is true or
the extent of the problems she experiences is described has
not been documented. Therefore, given (a) the increased
physical and psychological demands in providing care for
multiple care-recipients, (b) the potential for poorer health
outcomes for both the caregivers (NMs) and the care-
recipients (children and patients), (c) the increased likelihood
of NMs decreasing work hours or leaving the workforce,
and (d) the projected increased need for RNs, it is imperative
that we better understand the experiences of these NMs.

Approximately 15-20 NMs will participate in face-to-face
individual interviews where they will be asked to share their
caregiving experiences and how they manage their roles.
These interviews will provide data for the development of a
theoretical model demonstrating the experiences of these
NMs and how they negotiate and manage their caregiving
roles. This model can then be utilized in order to design
interventions that promote their personal and professional
health and well-being as well as the health and well-being
of those for whom they provide care. Preliminary findings
will be reported.

Technological Knowing: A Shared Engagement
in Nursing
Rozzano C. Locsin, RN; PhD, FAAN, Professor of Nursing,
Florida Atlantic University, Christine E. Lynn College of
Nursing, Boca Raton, FL, USA

This presentation describes technological knowing as
a way of knowing persons grounded in the middle-range
theory of Technological Competency as Caring in Nursing.
As a discipline and professional practice, nursing is
expressed as a shared engagement of human to human
caring. In technological knowing, there is a disciplined
intention, commitment, and active engagement focused on
using technologies to know persons more fully as participants
in their care, rather than as objects of our care. Technological
knowing is an illustration of this shared relationship – as
appreciating persons’ humanness, engaging in mutual

86 International Journal for Human Caring
A Journey of Learning to Love and Care for Self
Maryann Malloy, MSN, RNC-NIC, Einstein Medical Center, Philadelphia, PA, USA

Einstein Healthcare Network (EHN) adopted Watson’s Theory of Human Caring as the theoretical framework for nursing practice and the professional model of care delivery. Einstein Healthcare Network has been designated a Caring Science Affiliate by the Watson Caring Science Institute. According to Watson (2006), a value-based, theory-guided approach to caring and administration helps to make visible a caring model for professional nursing practice and system survival. Watson (2003) discussed the need for leaders to engage in more authentic processes and to practice compassionate service to self and others. Consistent with Turkel and Ray (2004) self-care is critical to health and healing. A leader who is holistic and self-caring creates harmony with others through authentic presence in the caring moment. If the leader does not compassionately care for self it is impossible to compassionately care for others. Our responsibility as leaders is to value, integrate, and role model the practice of loving kindness to self and others. My personal journey of learning to care for self became not just a project but a matter of self-renewal and a re-prioritizing of what is most important. Personal self-care included:

- Commitment to the Caritas Coach Program, including reading, journaling, and reflecting was life changing and remain part of my practice.
- Learning to take time for self, prioritizing family obligations, and creating quality family time, such as the family meal time and bedtime rituals.
- Utilizing the Caritas Process™ to accept positive and negative feelings regarding self and others.
- Tangible evidence of changes at work included maintaining normal work hours and leaving on time, making time for lunch with peers, and being conscious of time commitments for projects when asked to lead a group. Learning to accept limitations as it related to time commitments.

Practicing loving kindness to self-allow the nursing staff, patients, and families to feel cared for and provided tangible expressions of what the practice of loving kindness for self looks like. Outcomes within the NICU included integration of Watson’s Theory of Human Caring into practice, having self-care part of the evaluation, increased in family satisfaction, reduced blood stream infections, improved peer to peer collaboration, and acknowledgement by physicians of the change in the unit’s practice environment.

The Magic, Mystery and Miracle of “Koinoia”
Colleen A. Maykut, RN, DNP, Grant MacEwan University - Bachelor of Science in Nursing Program, Edmonton, Alberta, Canada; Tina South, RM, PhD(c), University of Western London, Paragon House, Boston Manor Road, Brentford, Middlesex, England, UK

Koinonia is a Greek word that suggests communion by intimate participation resulting in an exchange of thoughts and emotions grounded in common beliefs and values. A Community of Practice is a social arrangement which may facilitate individuals to discover with and from the other. This relationship may (1) promote capacity building from both an ontological and epistemological perspective; (2) facilitate reflective practice; and (3) demonstrate aesthetic expressions of caring. Thus, the International Association for Human Caring can be described as a Community of Practice which embraces Koinonia. The presenters will suggest approaches and strategies that may be adopted by the IAHC organization and its members to live caring as the essence of nursing.

Applying Roach's Six Cs of Caring to Gather Health Data through Telephone Interviewing
Christine Moffa, MS, RN; Ruth Tappen, EdD, RN, FAAN, Christine E. Lynn College of Nursing, Florida Atlantic University, FL, USA

Introduction: The use of the telephone to speak to study participants about health-related issues is useful when logistics make it difficult for participant and researcher to meet in person to collect data. However, gaining the trust of the participant can be a challenge, partly due to fears of fraud and identity theft. A spirit of openness and caring must come across the telephone lines between interviewer and interviewee. Roach’s six Cs can be applied to convey a sense of caring, thereby relaxing the participant and increasing their sense of safety to enhance the quantity and quality of health data being collected.

Theoretical Lens: According to Roach, caring is manifested through six Cs: compassion, competence, confidence, conscience, commitment, and comportment. Compassion is a connection in full presence, recognizing that the other may be experiencing a difficult time. Competence is having the skills and knowledge to perform within your scope of practice. Confidence refers to building trust, creating a context where information is believable and trustworthy. Conscience is caring guided by morals and ethical codes, to do what is best for the other. Commitment is standing by the other through the length of the relationship, no matter how difficult. Comportment is showing respect through speech, body language, and dress.

Application: Interviewers can be trained through role playing and scripting using Roach’s caring model. Compassion is expressed via understanding participants’
vulnerabilities and being sensitive to the anxiety and apprehension they may feel toward receiving a call from a stranger, who is asking about health-related issues. Competence is expressed by being able to give the participant the information they need to have an understanding as to what they are consenting. Confidence is achieved by ensuring the participant that the information they share will be used appropriately and for the greater-good. Conscience is expressed by following ethical research protocols, adhering to confidentiality, and respecting the relationship with the research participant. Finally, interviewers manifest caring through comportment by identifying themselves with their name, credentials, and institution; addressing the participant formally; using language the participant can understand; and projecting caring through tone of voice.

Implications: Telephone interviewing is a useful approach to data-gathering and Roach’s caring principles promise to optimize the value of the approach. Participants in telephone interviews often reveal personal information about their health, including details of physical, psychological, and emotional wellbeing. The public is repeatedly cautioned against giving out private information to strangers. People fear having their health information used against them when applying for life and health insurance and even employment. Fostering a caring relationship that gains participant trust will not only result in higher numbers of willing participants but the data collected are likely to be more meaningful. A caring telephone interview may not only reduce participants’ apprehension and anxiety, it could potentially increase positive emotions about helping others and create a sense of contribution and altruism.

The Forgotten Pool Nurse: Embracing the Difference Caring Makes by Utilizing the Relationship Based Care Model at a Magnet Institution
Donna Molyneaux, PhD, MSN, RN, CNE; Mary Vergara, CNRP, RN; Eleanor Gates, MSN, RN, Thomas Jefferson University Hospital, Philadelphia, PA, USA

Pool nurses are also referred to as temporary staff, flexible staff, non-standard employees, contact staff, and Per Diem Staff. The needs of pool nurses differ from full-time staff and permanent part-time staff. Traditionally, hospitals invest significant time and energy into their full or permanent part-time staff, yet the forgotten nurse is the “pool nurse.” Research suggests that pool nurses have more stress than permanent staff and have higher turnover rates, less job satisfaction, and less commitment than full-time, permanent employees. They are considered expensive employees with the quality of their work unequal compared to permanent employees. Aiken (2009) stated that although temporary (pool) nurses have been associated with poorer quality, other factors such as work environment are more likely to be the main cause.

Thomas Jefferson University Hospital is a large teaching Magnet Hospital in Philadelphia. There have been conscious efforts to ensure that the Professional Practice Model is practiced. The Care delivery model is the relationship-based care model. Staff is encouraged to use authentic caring in dealing with patients, families, visitors, coworkers, and the interdisciplinary team.

Special efforts were made to ensure that pool nurses are NOT the forgotten nurses at Thomas Jefferson University Hospital. The importance of embracing the difference caring makes with pool nursing staff will be shared as well as successful activities to sustain this caring will be discussed. In addition, data gathered about pool nurses perceptions will be reviewed.

Building Trusting Caring Relationships: Walking in the Shoes of Another
Deleta M. Moore, MSN, RN, Kaiser Oakland Medical Center, Oakland, CA, USA

Introduction: The practitioner to practitioner relationship requires the same consciousness of “being present, caring and honoring the unique subjective world of the other, openly listening with intent to hear the other’s point of view, and communicating congruence and differences effectively” (Watson, 2008, p. 97). One way for nurses to achieve more heart-centered, transpersonal caring relationships is to spend some time walking in the shoes of another.

Significance: Learning to honor, respect, and appreciate the gifts and talents each practitioner contributes to a caring team is overshadowed by the focus on individual performances, egos, and the differences of their specialties. This “silo” effect causes missed opportunities to understand and connect with each other and to strengthen that one common attribute that all nurses share—the ability and passion to care.

Purpose: The purpose of this project is to help nurses diversified in their specialties to develop a deeper understanding and appreciation of their caring connections, despite their different work settings, by spending time on each other’s units. The project is designed to foster discovery that nurse colleagues do share a common goal/bond of purpose and to build a more cohesive team that can talk about caring, creating healing environments, and practicing the Ten Caritas Processes™ as a universal mode of being, instead of being buried in the details of working with different patient populations.

Setting and Participants: The setting for this project is the Clinical Education Practice and Informatics (CEPI) Department at the Kaiser Oakland Medical Center which is composed of a team of 13 nurse specialists and educators. Participants were selected based upon their specialty and availability with six volunteering to participate in the first group.
Project Description/Process: Participants from the CEPI Department who volunteered were paired with a colleague with similar credentials, but who worked with different patient populations to lessen confusion with role delineation and function. Each participant spent a minimum of 6 hours in the peer’s unit, open to experiencing each other’s environment.

Project Outcome(s): After the experience, participants report a better appreciation for the work of their colleagues that diminishes the focus on differences and increases the understanding of their commonalities of caring as nurses.

Partial/Projected Evaluation: Authentic relationships have been strengthened by a growing understanding of what individuals share in common as opposed to their differences that can divide and isolate a team from connecting and understanding each other. It is projected that as the whole team is able to have opportunity to “walk in another’s shoes,” a new awareness of shared connections will increase team cohesiveness.

Future Directions: After all members of the CEPI Department have completed the experiential sharing, it is hoped that this project will extend to the Nursing Units so that nurses will have an opportunity to spend time with a peer on a different shift to decrease the perception that caring on different shifts is different.

The Miracle of CARING for the Neonate: State of the Science
Elizabeth Olafson, MSN, MSEd, RN-BC, Florida Atlantic University, Boca Raton, FL, USA/Florida International University, Miami, FL, USA

Introduction: The introduction of caring theory by Leininger in the 1970s led to inquiry into the phenomenon of caring in nursing. Leininger (1981) wrote “Caring is the central and unifying domain for the body of knowledge and practices in nursing” (p. 3). In the following years, theories of caring in nursing were developed and provided a framework for the study of caring in nursing. After 20 years of theory development, Swanson (1991) noted “caring has long been recognized as central to nursing” (p. 161). A look back at what had been studied in caring began with an eye on the future. Meta-syntheses written by Sherwood (1997) and Smith (2004) illuminated the importance in the application of caring to practice. The purpose of this abstract is to investigate the existing literature on caring for the neonatal patient revealing the state of the science.

Method: A literature search in both MEDLINE and CINAHL with the key words of caring or caring theory and the word neonatal revealed 15 articles reflecting caring and the neonatal patient. All searches were limited to English language, peer-reviewed publications between the years of 2002 and 2012 and addressing a population of infants and neonates. Articles were excluded when the words care or caring were used to describe tasks or skills and not related to what is known in caring theory. This search of the literature revealed themes found in the literature related to caring and the neonatal patient.

Results: Three main themes were discovered in the caring literature related to the neonatal patient. Articles revealed caring in behaviors or concepts, applications of caring theory, or identification of caring theory reflected in the findings. Caring behaviors/concepts identified in 8 articles included knowing, comfort, nurse-patient connections, presence, touch, and caring as competence. The caring theories of Watson, Boykin and Schoenhofer, Duffy, and Leininger were found to be applied in five of the articles reviewed. Two articles identified caring theories as evident in data revealed to the authors. One article applied Watson’s theory to a research study.

Discussion: A search of the literature revealed opportunities for development of the application of caring theory to neonatal patients and their family. It is important to study practices in the neonatal intensive care unit with a caring lens, because “the technical aspects of care can consume the attention of care providers, who miss opportunities for human connections” (Gordon & Johnson, 1999, p. 406). Watson and Smith (2002) described caring as “a philosophical-theoretical-epistemic undertaking, not just a nice way of being” (p. 453). This philosophic, theoretical, epistemic way of providing care to neonates and their families may profoundly affect outcomes. Even when the focus was not caring theory, concepts of caring were identified in case studies, care models, and research studies. The literature presented is a good beginning in the study of caring for the neonatal patient. The reviewed journal articles concluded that expressions and application of caring theory in diverse situations were congruent with and contributed to positive perceptions of care provided to neonates and families. The lack of literature located on the application of caring theory to research on neonatal patients suggests an opportunity for future investigations.

The Impact of an Educational Intervention on Nurses’ Knowledge and Caring Behavior
Francesca Onyeyuruwa, PhD(c), RNC; Sharon L. Dormire, PhD, RN, Florida Atlantic University, Boca Raton, FL, USA

The late preterm infant (LPI) is defined as an infant delivered between 34-36.6/7 weeks post conception. In the U.S.A, over 70% of all preterm births are late preterm (National Vital Statistic Report, 2011). The LPI experiences more health challenges with a higher morbidity and mortality rate than his/her full term counterpart. Complications and risks associated with being a LPI account for significantly increased hospital costs related to readmission in the first 30 days of life (March of Dimes, 2009). While the economic and epidemiological impact of LPI status has been explored, there
is a paucity of research related to nursing care of the LPI and related educational needs of healthcare providers.

The purpose of this quasi-experimental, repeated measures, one group study is to examine the effect of an educational intervention using Swanson caring theory on: 1) the nurses’ caring behavior and knowledge regarding interventions for LPIs and their families, and 2) the incidence of LPIs’ hospital visits and readmission rates for hyperbilirubinemia and dehydration.

This study will be conducted at a community hospital in South Florida. All nursery and postpartum nurses at the study hospital will be invited to participate. As a baseline measure, all participants will be asked to complete computer-based forms of the Late Preterm Knowledge Instrument (LPI-KI) and caring behavior pretest (Late Preterm Infant Caring Professional Scale (LPI-CPS)). After the pretest is completed, a two-hour educational intervention will be provided. The curriculum of the intervention will focus on the characteristics, physiological needs, associated risks, and nursing management of LPIs, incorporating Swanson’s theory of caring. Immediately following the intervention session, the participants will complete a computer-based knowledge posttest using the Survey Monkey link. Certificates for two continuing education units (2 Contact Hours) will be given to all participants after the posttest is completed. In order to complete a one-month follow up, a separate e-mail account will be set up through Survey Monkey for participants to provide contact information. This will allow a separation of survey responses and participants’ contact information to ensure anonymity. Data will be analyzed using repeated measures ANOVA for comparing participants’ tests scores at the different intervals, and multiple linear regression to identify significant predictors of outcomes.

This inquiry is intended to contribute to nursing knowledge regarding the care of LPI infants by identifying effective strategies to enhance caring behavior and improve outcomes. It is hypothesized that the educational intervention will contribute to better management of the LPI before discharge from the hospital. The assumption is that nurses knowledgeable about the LPIs’ care needs will be better able to care for and educate the family before the infant is discharged. Ultimately this should reduce the cost of readmissions and hospital visits. If effective, a structured intervention may be a cost-effective strategy to improve outcomes for the LPI. Although data collection is in progress, analysis will be completed before this presentation.

The “Magic, Mystery and Miracles” of Answering “A Call to Arms”: Earth-Caring in Education, Practice, Research, and Advocacy

Robin E. Pattillo, PhD, RN, CNL; Lisa Jordan, PhD, RN; Kathleen Jackman-Murphy, MSN, RN; Barbara Sattler, RN, DrPH, FAAN, University of Iowa College of Nursing, IA, USA

During each and every moment in time a nurse somewhere is “Answering the Call to Arms,” using that particular brand of “Magic, Mystery, and Miracles” unique to nursing. Nurse educators, practitioners, advocates, and researchers are employing their brand of magic to promote healthier environments for all. Nurses understand the unique mystery associated with the miraculous impact a healthy environment can have on the well-being of friends, family, students, and communities. Nurses in practice, research, education, and as advocates are in the rather magical position of being trusted by healthcare consumers to promote healthier life processes. The public sees the magical mystery of nursing miracles everywhere – the places we work, live, learn, and play. Thus nurses can readily support, coordinate, mediate, and collaborate with members of the community to promote earth-caring. Practicing nurses effectively communicate the almost magical association between the environment and the health and well-being of all. Nurse educators are teaching students the miraculous benefits of reducing stressors, such as sounds, smells, and toxins while providing patient care. Nursing students can embed their knowledge into the magic of their role in learning and living communities. Additionally, nurse leaders advocate for healthy communities and miraculously alter legislation that addresses environmental issues impacting our health. Nurse researchers employ the magic of evidence to dispel the mystery of the impact of the environment and nurse caring on practice, education, and advocacy. This symposium will present the “Magic, Mystery and Miracles” achieved by those nurses who express earth-caring by answering “A Call to Arms.”

Implementation of a Consent Training Program for Nurses: Ensuring Consistent Informed Consent Procedures in Palliative Care Research

Gail Pittroff, PhD, RN; Verna Hendricks-Ferguson, PhD, RN; Vicki Boehmer, BSN, RN, Goldfarb School of Nursing at Barnes Jewish College, St. Louis University School of Nursing, Missouri Baptist Medical Center, St. Louis, MO, USA

Research studies have provided evidence that the quality of informed consent in clinical research is often sub-optimal. A major tenet of human subject protection guidelines related to research study participation is that informed consent procedures for clinical research should be an on-going process, which begins, rather than ends, with participants’ initial consent. Also, informed consent is an integral part of clinical research and it is viewed as an ethical concern in
vulnerable populations, such as adult patients who have received a referral for palliative care (PC) support. To date, lacking are reports on the training procedures used to equip nurses to adhere to required informed consent procedures when screening adult patients receiving PC for research participation. Our purpose was to describe training and documentation procedures used in a pilot study to prepare PC nurses to conduct informed consent procedures when enrolling eligible adult patients. The eligible patients were invited to participate in a semi-structured interview with trained nurses after receiving a referral for PC support. The training of the PC nurses for this study was conducted during a 4-hour training meeting with the two co-investigators. The investigators reviewed the informed consent procedures and related documentation of consent procedures. The nurses participated in role-playing activities to increase their confidence and competency in conducting informed consent procedures. The nurses also received a study manual that included an outline of the informed consent procedures, the consent tracking form, and a sample consent form.

The findings reveal the challenge of ensuring adherence to informed consent procedures requires a comprehensive training program that includes didactic review of the procedures, role-playing activities, debriefing feedback, and documentation of all consent procedures. Key documentation included: (a) dates and initials of team members who introduced the study and reviewed the consent forms; (b) time allowed to review the consent forms; and (c) reasons why eligible patients may have declined participation and consented participants may have withdrawn from the study. Implications of this study reveals that an educational program for nurses to consistently implement consent procedures may help to reduce ethical concerns related to research participation by improving communication between nurses and screened participants.

Acknowledgements: This study was partially supported by the Missouri Baptist Medical Center Faculty-Staff Collaborative Grant Program in St. Louis, MO, USA

Touch as an Essential Expression of Caring for Thai Family Members Attending their Loved One with Traumatic Brain Injury
Duangporn Piyakong, MSN, PhD student; Patricia Liehr, PhD, RN, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

Introduction: Traumatic brain injury (TBI) is a major health problem in Thailand. It results in unconsciousness with physical, cognitive, emotional, and social consequences. Most patients with severe TBI are always in the state of unconsciousness and it is very difficult to predict when their consciousness will return. Some have an improved state of consciousness in a few days, a few weeks, or a few months; some show no changes in consciousness: and some die. Therefore, severe TBI is a devastating injury for not only patients but also their family members due to the uncertainty of illness. Touch is an important approach to increase the level of consciousness in brain injured patients and family members can apply it while involved in caring for their loved one. Auditory touch, defined as a healing sound strategy for improving the state of consciousness, was evaluated in this study by exploring Thai family members’ approach for caring for their loved one who was in the state of unconsciousness.

Methods: This theory-guided pilot study used an exploratory descriptive design. Nine Thai family members of severe TBI patients were interviewed at the neurological intensive care unit of Buddhachinnaraj Hospital, Phitsanulok Province, Thailand. Story-inquiry method guided data collection and analysis. The interview asked about how family members engaged with their loved one, the results of their engagement, and what sounds were appropriate for comforting their loved one. Inductive strategies were used to analyze data.

Results: Essential approaches participants used while engaging with their loved one included not only auditory touch but also haptic touch. Participants explained that they provided auditory touch by using family voices (n = 9), Buddha teaching sound (n = 2), and the patient’s favorite songs (n = 1). Moreover, participants also described that they applied haptic touch through shaking their loved one’s hands or arms (n = 5), touching the patients’ face or other body parts (n = 6), and doing a massage (n = 4). More than half of all participants described that their loved one sometimes responded to their approach by moving eyelids, fingers, arms, or legs.

Discussion: Both auditory and haptic touch are crucial approaches for Thai family members caring for their loved one who is in the state of unconsciousness. Although the approaches cannot recover the state of unconsciousness, family engagement may increase the probability of improving the level of consciousness. Results will guide development of a model by incorporating auditory and haptic touch as healing modalities to increase the state of consciousness in TBI patients. Moreover, the model will be useful to guide appropriate interventions for nurses and family members in using both touches for improving the state of consciousness in TBI patients.

Nursing Education to Alleviate the Suffering of the Healer
John Rowe, PhD, RN, Massachusetts College of Pharmacy and Health Sciences, Manchester, NH, USA

Caring for people who are suffering is hard work and can exact a high toll on the one who cares. This toll has been examined under the concepts of stress, burnout, compassion fatigue, and secondary post-traumatic stress. Another approach has been the concept of the suffering of the healer, defined as the acute distress associated with events that
threaten the intactness of the healer in the role of healer. A study conducted with 25 registered nurses revealed that most described having experienced such suffering and that the threats of vulnerability, reverberations with the past, guilt, and the high cost of empathy were among the major contributors to their suffering. This presentation will report on a portion of that study that focused on participants’ perceptions of how their nursing education had prepared them to cope with suffering of the healer and how nurse educators could do a better job of preparing them. Although many believed that there was little that could have been done ahead of time, several participants made several recommendations for changing how education programs addressed this topic.

The presentation will also address how the author has addressed the suffering of the healer in the courses that he has taught. These include the use of art and literature to explore responses to suffering including our own, helping students to explore their own affective response to the patient in clinical and direct information about the concept of suffering of the healer.

Older Persons with Alzheimer’s Disease – Being Present with a Therapy Dog May Reveal Episodes of Lucidity
Anna Swall, RN, PhD student, Neurobiologi, Caring Science and Social Science, Karolinska Institutet, Sophiahemmet University; Carina Lundh Hagelin, Sophiahemmet University, KIDS, LIME; Brit Ebbeskog, RN, Neurobiologi, Caring Science and Social Science, Karolinska Institutet; Ingegerd Fagerberg, RN, Neurobiologi, Caring Science and Social Science, Karolinska Institutet. Ersta Sköndal University

Background: The incidence of Alzheimer’s disease (AD) increases along with an older population worldwide. Behavioral and psychological symptoms of dementia (BPSD) are behaviors difficult to deal with for the person with AD and caregivers. Animals have been included in the environment for persons with AD for some time. Animal Assisted Therapy (AAT) includes prescribed therapy dogs that visit the person with AD with a specific purpose.

Aim: This study aims to illuminate the meaning of older persons with AD lived experience of interacting with a therapy dog.

Method: Video recorded films were conducted from every person (five participants) with AD visits of the dog and its handler (10 times/person). The films were transcript and analyzed with Phenomenological hermeneutics.

Results: The main theme “Being aware of one’s past and present existence” meant to connect with one’s senses and memories and to reflect upon the situation with the dog by feelings and remembering present and earlier times. The moment with the dog shows through retold memories and feelings, and enable a possibility to reach the person on a cognitive level in the present moment.

Conclusion: The study might contribute to facilitate the interaction between the person with AD and the caregiver at the ward.

Empathy in Nursing Students over the Educational Program
Donna Taliaferro, RN, PhD; Holly Diesel, RN, PhD, Goldfarb School of Nursing at Barnes Jewish College, St. Louis, MO, USA

Nursing educators have traditionally been challenged to provide the necessary education to address licensing in the US and around the world. However, faculty have noticed during the educational process, students may change the way in which they demonstrate caring behaviors with altered degrees of empathy. Educators may have an influence in this without knowing it. Nursing faculty are required to combine scientific knowledge with technical skills but tend to omit the unique components of the nurse-patient, nurse-nurse relationships. Empathy is a core component of these relationships and has a direct link to patient outcomes and working relationships. LaMonica (1983) stated that empathy is a basic human need. Being able to be empathic is critical when patients are at their most vulnerable state.

White (2006) noted that over time there is a cost to the facility as a result in dealing with employees that are stressed. Increased absenteeism and morale problems result in poor of quality of care.

Loss of empathy during the academic program sets students up for problems within their first job and potential for compassion fatigue early on. A research study is ongoing to evaluate empathy at the beginning and end of two schools of nursing: Finland and the US. Initial data has determined baseline findings of empathy at the beginning of the program.

The Implementation of Caring Groups in an Online Course: A Phenomenological Study
Susan Welch, EdD, RN, CCRN, CNE; Colleen Needham, MSN, RN, FNP, University of West Georgia School of Nursing, Carrollton, GA, USA

The purpose of this qualitative study was to explore the experience of RN-BSN nursing students in an online course that implemented Caring Groups as an experimental teaching/learning strategy for caring. The University of West Georgia School of Nursing has utilized Caring Groups as a teaching strategy since 1992, but never in the RN-BSN program. Growth and implementation of online programs created a more complex environment that necessitated a reconceptualization of the current Caring Groups. The new structure was implemented in spring 2012. Interviews with current graduates were needed to understand the implementation of Caring Groups in an online course. Data from audio-recorded interviews were analyzed to discover the
experiences of being in a Caring Group in an online course. Students were asked to participate in individual interviews after graduation from the program in August 2012.

Intentional Listening Presence: A Model of Caring
Lisa Kirk Wiese, MSN, RN, Doctoral Nursing Student, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA

Introduction: In a radical shift from a focus on nurses accomplishing tasks, hospitals are beginning to mandate that nurses spend at least five minutes per shift talking with each patient. While five minutes per patient seems a miniscule amount of time, administrators are recognizing that for nurses, onerous responsibilities and a consuming focus on completing tasks are displacing the art of nursing. Patient satisfaction surveys reveal what nurses have always known: patients need and desire caring nurses who have time to listen and be with them.

Purpose: A Model for Intentional Listening Presence was developed to show the relationship between the caring nurse who elicits (or initiates) the nursing situation (or interchange or interaction) from a stance of authentic presence, and the need of the patient to be heard. The purpose of this model is to guide and empower nurses to care effectively for their patients.

Model: In this model, caring intention is the foundation from which the nurse responds to the call to care. Compassion is recognizing and responding to the patient’s needs. Perception is the means by which the caring nurse achieves understanding in the moment and is open to the person being nursed. Both nurse and patient grow in a rhythm of intentional caring; listening, opening, and sustaining presence.

Implications for Practice: The interconnectedness of these concepts within the nursing situation illustrates an Intentional Listening Presence through which both patient and nurse may co-create healing.

CARITAS POSTERS

Transforming Nursing Language through Storytelling
Discovering Awe and Wonder through Caring Moments
Mark D. Beck, BS, MSN, RN-BC, Kaiser Foundation Hospital East Bay, Oakland, CA, USA

Introduction: The current language of nursing practice is informed by the empirical medical model to the exclusion of other ways of knowing, being, and doing. Nurses have forgotten that they are responsible for, first and foremost, Spirit-to-Spirit and Caring Healing Relationships for self, patients, and families, Kaiser Foundation Hospital East Bay, and the healthcare community. Establishing language centered on caring intentions and moments is always a challenge, especially for nurses whose conceptual thinking is molded by an empirical medical model, traditional performance measurements, and the absence of professional standards for creating healing relationships. Storytelling caring moments offers nurses an opportunity to remember what they value most, heart-centered, transpersonal, holistic, and integrative care filled with moments of awe and wonder. Storytelling allows the nurse to awaken to Caring Moments, experience transformation, and co-create a culture where caring science language becomes the new natural language of nursing in all-nursing situations.

Significance: Environments where nursing remembers its roots in all ways of knowing and infuses caring science language as the natural language of nursing will be healing to the nurse, other colleagues, and promote healing for the patients, the organization and thus the universe.

Setting and Participants: The Nurse Practice Committee is the working group of staff nurses from all the units of the medical center that addresses nursing practice in policy. The participants are comprised of staff nurses from all specialties and units, and the CNSs from the CEPI (Clinical Education, Practice and Informatics) department.

Project Description/Process: The meeting structure was reformatted to include a centering moment conducted by a member of the CEPI department to set the tone for the meeting. As a requirement for participation staff members were asked to bring a caring moment story to share at the closing of the meeting.

Project Outcome(s)/Projected Outcomes: The intended outcomes are to increase caritas consciousness, and the awe and wonder of nursing within the informal network within the Nurse Practice Committee; to help them again see the beauty of nursing with a language to describe it; and to compile a list of creative language patterns for transforming the old medical model language into a new nursing caring-healing language.

Future Directions: The future direction will be to have this restructured time serve as a model for other meetings within the Patient Care Services division. In addition, an evolving covenant of “What the new nursing caring-healing language looks like” might be developed system-wide with integration into nursing documentation, “performance-presence” evaluation, article, or presentation at a conference.

Integration of Caring Behaviors on an Educational Team
Marilee Ford, RN, BSN, MA, Kaiser Permanente Santa Rosa, Santa Rosa, CA, USA

Introduction: At Kaiser Permanente Santa Rosa, the team of professionals comprising the Clinical Education, Practice, and Informatics team have varying levels of competency in the use of the Theory of Caring Science.

Significance: Clinical Educators are a unique group of professionals working in any hospital environment. While
they usually do not provide direct patient, they are in a position to influence any direct patient caregiver, from the RNs to the PCTs to UAs. If a facility is to fully integrate the Theory of Human Caring as a nursing model, which is the intention in the Northern California Region of Kaiser Permanente, it is important that every educational effort include Caritas as a basic underpinning. It is this author’s supposition that full integration cannot occur unless the group of educators understands Caring Science and practices its principles with competence as members of their home educational team.

**Purpose:** The purpose of this project is:
1.) to introduce/review the principles of Caring Science;
2.) to provide an experiential encounter with the Caritas Processes;
3.) to support staff in creating a visual representation of their growth;
4.) to support integration of Caritas Science in our departmental educational efforts;
5.) to evaluation if experiencing the Caritas Processes as a department changes the results of the Peer Group Caring Interaction Scale

**Setting and Participants:** Kaiser Permanente Santa Rosa, group setting with participants who are members of the CEPI team. Number of participants: 6.

**Project Description/Process:** Six hour-long sessions in which two Caritas processes are covered per session: Each session includes a brief didactic portion, followed by an experiential process that demonstrates and encourages the participants to engage with the featured Caritas Process(es) of the day. The sixth session will be used to summarize, talk about the process as a group, and brainstorm ways to integrate Caring Science into future educational offerings, as well as to celebrate completion of the program. The Peer Group Caring Interaction Scale will be completed on a voluntary basis before and after the classes begin and end.

**Development of Nursing Students’ Caring through Reflective Practice**
Sheryl Jacobson, RN, MS, Viterbo University, LaCrosse, WI, USA

Ask beginning nursing students why they chose the nursing profession and many will state “because I want to help people, I want to care for them.” Ask advanced students what they are doing in nursing school and they will talk about the technical skills, the exams, and the clinical simulations. Often nursing education focuses on the perfection of skills and tasks, the “doing”, rather than the “being.” Yet it is apparent in numerous studies that what patients (and students) want is a competent nurse who also cares. As more and more evidence accumulates to support the need for human caring in our health care systems, alongside our technical skills, nurse educators have a responsibility to honor this way of being and help facilitate nursing students’ growth into caring practice. The purpose of this project was to engage nursing students in the development of reflective practice in order to recognize multiple ways of knowing, to learn core concepts of the Theory of Human Caring, and to develop an intentional consciousness of caring behaviors that will direct their nursing practice. The project involved 25 undergraduate baccalaureate degree seeking nursing students in their senior year at a small university in western Wisconsin. A video presentation was developed, based on a patient’s lived hospital experience, depicting caring versus non-caring behaviors. Students were asked to engage in group discussions about the behaviors they observed. Following the classroom experience, students were asked to reflect back on a personal or professional experience they have had with caring and non-caring behaviors. They were asked to write about the experience, or submit an artistic expression (picture, poem, song), describing what the experience meant to them, how they were affected by it, and how they will use it in their nursing practice.

Qualitative evaluation found that students identify the importance of being present, authentic caring relationships and attending to basic human needs as critical areas of caring consciousness. Students demonstrated increased awareness of multiple ways of knowing and the importance of incorporating these ways into their nursing practice. Future directions with this work will involve:

- Incorporation of a measurement tool for nursing students to self-assess their caring behaviors during a clinical experience at a homeless shelter.
- Identification and documentation of caring interventions into an electronic medical record, following a simulated home care visit.
- Revision of a journal assignment asking students to consider how the environment affects healing and the influence the nurse has on that environment.

**Complicated Grief: Healing Emotions after Loss (HEAL)**
Mary Kelly, RN, BSN, MEd, Bronx, New York, NY, USA

This research is to increase knowledge and understanding between grief and complicated grief in assessment skills and the latest clinical treatment options. There is limited understanding between grief and the complexities of complicated grief assessment and caring treatment modalities. The significance of this poster is to increase and to enhance the professional’s knowledge, understanding and caring skills related to complicated grief with the most current research findings. Complicated Grief Treatment utilized through a professional, structured, caring, and therapeutic relationship can offer hope and positive outcomes after significant losses. The Complicated Grief program is currently being utilized throughout the United States and worldwide. Complicated Grief is not the same as grief or bereavement. Current research findings suggest that specific, structured, caring applied as Complicated Grief
Treatment can provide healing after loss for the suffering person. Care professionals have the unique environment to assess individuals and refer for treatment options.

Watson’s Theory of Human Caring Harmonizing with Nursing Documentation
Sharon Sauer, RNC-NIC, BSN, Einstein Healthcare Network, Philadelphia, PA, USA

Introduction: Einstein Healthcare Network (EHN) adopted Watson’s Theory of Human Caring as the professional practice model for nursing practice in 2007. In 2011, EHN was designated a Caring Science Affiliate by the Watson Caring Science Institute. In 2011, EHN introduced computerized documentation within the network. Prior to the care plans becoming a part of the electronic documentation, a written version of the nursing care plans with Watson’s Theory of Human Caring was envisioned in the Neonatal Intensive Care Unit (NICU). Integrating Watson’s Theory of Human Caring into the nursing care plans moves from a technical based nursing documentation to a caring theory based framework which includes the Caritas Processes™ and caring-healing modalities. There is empirical evidence on registered nurses contributions to quality patient care. However, the value in revising the electronic documentation is to implicitly link caring-healing modalities and nursing care framed in caring theory to patient quality outcome data.

Program Description: As a Caring Science Affiliate, registered nurses working in the NICU at Einstein Healthcare Network have been using the theory to inform and guide practice. The NICU nurses readily embraced the concept of transforming the language of the nursing care plan to be congruent with the language of the theory. Under the guidance and mentoring of a Caritas Coach, a group of nurses was chosen to integrate the theory’s language into the nursing documentation. The purpose of this change was to communicate in writing the intentionality, will, and commitment demonstrated by the registered nurses during daily practices at the bedside. Adding the theory into the nursing care plans enables nursing to document for the first time the human-to-human experiences that are meaningful, authentic, and intentional.

Theoretical Framework: A group of eight innovative and creative Caritas Nurses were part of the design team. Each registered nurse was assigned two or three care plans to revise the language using the theory as a foundation. The following changes were applied to the care plans Nursing Diagnosis-Patient Problem to Nursing Diagnosis-Recognizing Patient Needs, Outcomes to Importance to Patient, Interventions to Caring Healing Modalities, and the Language – allow, partner, establish, connect, collaborate, encourage, assess, create, provide, understand, and anticipate was integrated throughout the care plans. Along with these changes, a list of the Ten Caritas Processes™ was integrated into the care plan. The process allowed the nurse to record the Caritas Processes™ according to the recognition of the patients’ needs.

Results: Two outcomes were noted. First, transforming the nursing documentation with the caring language increased the registered nurses understanding of the Caritas Processes™ when expressed through tangible nursing practice. Second, the value of the theory guided practice and caring healing modalities were enhanced.

Conclusion: With the integration of Watson’s Theory of Human Caring into the NICU care plans, the language will exhibit authentic caring relationships, caring consciousness, and wholeness of mind-body-spirit within the documentation.

Caritas: Radiating Light into Institutional Darkness
Carol A. Sewter, RN-BC, HN-BC, Einstein Healthcare Network, Philadelphia, PA, USA

Introduction: During 2011, the Department of Nursing at Belmont Center for Comprehensive Care entered into a very “dark” period. Staff nurses and behavioral health associates lost trust in nursing leadership and needed to begin to rebuild trust. To support the staff and help them move forward, we needed to give voice to the darkness or the Via Negativa (Fox, 1991) so they could move into the light. We were beginning to emerge from the darkness when two serious patient events occurred, causing pain, stress, and further darkness.

Significance: It was meaningful and significant to give voice to what staff had been through in the past year in order to create a sacred and healing environment where they could flourish and continue to care for patients as well as each other.

Purpose: To increase staff awareness of Watson’s Theory of Human Caring (Watson, 2008) and the value of self-care, and to integrate caring science to move the organization from darkness into light.

Setting and Participants: This initiative took place in two different formats. The Celebration of Caring was open to all staff and all the hospital departments. The united base education was specific to the 2 East/North Unit, a 21-bed Eating Disorder and Mood Disorder Psychiatric Unit.

Project Description: The project focused on educating the staff on Watson’s Theory of Human Caring and the Caritas Processes™ in experiential ways. A Celebration of Caring was held at various times for all staff within all hospital departments. The Practice of Loving Kindness to Self™ was lived out via hand massages and the creation of aesthetic mirrors for staff lockers focused on authentic presence. Handouts explaining the Caritas Processes™, book markers, and a meditation CD were given to all. The 2 East/North project integrated the principles and language of caring science into practice. The education started with candle lighting and centering. Staff were introduced to the concept...
of touchstones and Heart Math. Articles related to caring, concepts related to energy, and how negative energy destroys the unit milieu were shared with all.

**Outcomes:** The intended outcome was to create a healing environment that nurtures and supports self-care to move from a biocidic to a biogenic healing environment (Hallíardsdóttir, 1991). An unexpected outcome that occurred was the Executive Board of the hospital requesting a formal presentation on caring science. The Caring bulletin board is in place and staff value recognizing caring moments. Qualitative responses to the Celebration of Caring included “I am thinking differently about authentic presence with patients,” “I never thought about the importance of caring for self as making a difference in how I care for others,” and “what a fun way to learn, we need more days like this.” Responses from the unit based education included: “setting up the room and centering made a difference, we were all more receptive” and “Carol gave us a lot to think about in terms of how negative energy affects the milieu.”

**Caritas Consciousness Intentionality and Caring Healing Modalities for Pain Relief**

Nancy Swartley, RN, MSN, Einstein Medical Center, Philadelphia, PA, USA

**Objectives:** The purpose of this project is two-fold. First, to provide experiential education to help registered nurses develop Caritas Consciousness and second, to introduce the caring-healing modalities of music, aromatherapy, hand/back massage, relaxation, and breathing as alternative methods of pain relief to the existing pharmacologic pain regimen. Significance: Managing pain related to acute postoperative or traumatic injury presents challenges for both patient and nurse. Registered nurses are frequently frustrated by an inability to effectively manage pain resulting in feelings of inadequacy when focusing on Developing and Sustaining a Helping-Trusting Caring Relationship™ (Watson, 2008) with patients. Watson (2008) reminds us that a transpersonal caring relationship is foundational to becoming aware of another’s frame of reference; recognizing the experience and meaning of pain from the patient’s point of view allows the registered nurse to provide pain relief while creating a caring moment between nurses and patient. Moving from pain relief as a task to pain relief as a caring moment requires the nurse to expand Caritas Consciousness and research has shown that caring-healing modalities provide effective pain relief that will foster the patient experience.

**Method:** Caritas education has been an ongoing process on the unit for the past two years. The purpose of the experiential education was to have the registered nurses understand how they are the caring-healing environment when they enter the patients’ room and how it relates to authentic presence, authentic listening, intentionality, transpersonal caring moments, and centering as the science behind the art of nursing. Once the education is completed the actual project will begin. Patients will be given a decorative card and invited to choose from caring-healing modalities including music, aromatherapy, massage, relaxation, and breathing techniques as an alternative to the traditional pharmacologic modalities. Patients will be assessed for pain relief and pharmacologic pain relief provided if needed.

**Results:** The intent is to develop a comprehensive pain relief program incorporating both traditional pharmacologic and non-traditional caring-healing modalities for pain reduction and/or complete pain relief. As nurses practice Caritas Consciousness, integration of the theory into practice will expand, RN engagement will improve, and the introduction of caring healing modalities for pain relief will enhance the patient experience as a whole and specifically in terms of pain relief.

**Conclusions:** Informal feedback from the registered nurses has been positive and the experiential learning activities are helping them understand the concepts of Caritas Consciousness and “being the caring-healing environment.” A formal survey for patients will be developed to measure pain relief with the caring healing modalities, and response to pain management will be monitored via patient satisfaction data. A long-term goal is to expand the program to other units in the hospital and to have the registered nurses involved in the pilot program certified in holistic nursing.

**Creating an Educational Curriculum that Embraces Caring Science**

Jacqueline Werner, BSN, RN-BC, ONC, Kaiser Permanente Oakland Medical Center, Oakland, CA, USA

**Introduction:** Health care is constantly changing. There is a constant need to make sure our nursing staff is current on new equipment, aware of new regulations, and is using evidence-based practices. The importance of maintaining and improving standards is overwhelming to staff and the educational department. By creating a curriculum that includes Caring Science, it helps us move from the empirical medical model, and allows us to embrace a model of care that focuses on a healing caring relationship. It also allows healthcare practitioners to practice self-care which is important in this stressful environment.

**Significance:** Creating a Caring Conscience requires having a common language. By creating a curriculum that includes Caring Science the frontline caregivers will start to develop a common language. This is important because it allows frontline caregivers to unite and work for a common goal. As Caring Science spreads to our frontline caregivers, it will create a healing environment that embraces authentic relationships between caregiver and patient, and changes how care is delivered.
Purpose: The purpose of this project is to develop an education curriculum that is based in Caring Science. Setting and Participants: This project was implemented at Kaiser Permanente facility in Oakland, California during the annual training for the medical surgical and medical telemetry units. 280 Registered Nurses attended the training. They included staff nurses, assistant nurse managers, and unit managers.

Pilot Description/Process: The training started with a centering activity that set the tone for the training. The centering activity allowed participants to be able to focus on the training. During the training there were three Caritas exercises. The first exercise was comparing and contrasting the differences between caring for a patient where the nurse is authentically present, and has developed a connection versus caring for a patient where there was no connection, and the nurse was not authentically present. The second exercise was having the participants find a partner. One person in the pair told the other a story for two minutes without interruption. After two minutes the person who was listening had one minute without interruption to express to his/her partner what they heard and felt during the story, then the pair had one minute to discuss how close the meaning of the story was conveyed. After the exercise the whole group discussed how they felt during the exercise and how we can incorporate this into our practice on the units. The last exercise was a discussion on what nurses do for their own self-care during work and at home.

Pilot Project Outcome: The intended outcomes are to introduce Caritas concepts and to start develop a Caring Consciousness in the frontline nursing staff.

Pilot Project Evaluation: For many of the nurses this was the first exposure to Jean Watson’s Caring Science theory. As the training progressed the nurses were able to verbalize key concepts of the authentic relationship. They recognized that the core concepts of the theory are aligned with the reason they entered into the nursing profession. The discussion regarding self-care was difficult because this was the first time many of them were asked about self-care. As the discussion progressed, the concepts of self-care were embraced by the nursing staff. After the training a formal written evaluation was given to the participants. Many of the staff indicated that it was very useful for their bedside care. Some of the comments that were on the evaluations were that the training was “very helpful,” “I’m glad we are taking about caring,” and “This is why I went into nursing.”

Future Directions: To have Caring Science as a thread for all of the educational offerings. This will be done by using Caring Science language, experiential activities, and allowing nurses to tell their stories. The hope is to increase the awareness and understanding of Caring Science. This will have a powerful effect on our organization and change our environment to a healing caring experience for all.

Student Posters

The Magic of Caring in the Operating Room: The Nursing Situation, Answering the Call, and Engaging in the Dance
Student: Florence Cooper, RN, BSN, CNOR; Mentor: Savina O. Schoenhofer, PhD, RN, University of Mississippi School of Nursing, Jackson, MS, USA

The operating room (OR) is a highly technological environment with limited time for awake interaction with patients. The purpose of this poster is to provide a technical and aesthetic example of nursing as caring in the OR and to set the groundwork for further phenomenological research.

The poster’s theoretical basis begins with, “Caring as helping the other grow,” (Mayeroff, 1971, p. 7) and “Caring is identified as the core of nursing” (Roach, 1992, p. 17). Second, Boykin and Schoenhofer’s nursing as caring theory (2001) is utilized to illustrate the nursing situation, “A shared lived experience in which the caring between nurse and nursed enhances personhood” (Boykin & Schoenhofer, 2001, p. 13), the call for nursing, an “acknowledgment and affirmation of the person living caring in specific ways in this immediate situation” (Boykin & Schoenhofer, 2001, p. 13), and the dance of caring persons, “being for and being with the nursed” (Boykin & Schoenhofer, 2001, p. 13). Finally, Loscin’s middle range theory, technological competency as caring (2010) is utilized to illustrate the worth of technological means “used in the practice of knowing persons in nursing” (Loscin, 2010, p. 461).

The author provides a personal description of a nursing situation in narrative form, from technical and uniquely nursing aesthetic perspectives. As a result of this experience, she wishes to explore other OR nurses’ caring situations, i.e., how they answer the call for nursing and their engagement in the dance, through the use of phenomenological research techniques.

Community-based Approach to Care for Older Adults
Chuleekorn Danyuthasilpe, RN, DPh, Post Doctoral Student of Caring and Visiting Scholar at Florida Atlantic University, Faculty of Nursing, Naresuan University, Phitsanuloke, Thailand; Mentors: Charlotte D. Barry, RN, PhD, NCSN, Rozzano Loscin, RN, PhD, FAAN, Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Ratlon, FL, USA

Introduction: A community-based approach to care provides the framework for a research study conducted in a rural sub-district in Thailand. The purpose of this presentation is to describe the study and findings that highlight the need for health care that is community-based, collaborative, and respectful to enhance the wellbeing of older adults.

Method: A qualitative study design was used to explore the elements of community based health care for older adults. The objective of this research was to understand and to
describe roles of community care for older adults. The 59 participants included village headmen, nurse, public health personnel, family caregivers, village health volunteers, and members of local administrative authorities. The participants were asked open-ended questions related to roles and responsibility of community caring for older adults, how community perceives health care services for older adults, and how community participates in caring. Data collection included focus groups, observations and field notes.

**Results:** Participants stated that Thai older adults have a value and deserve to receive caring from loved ones. Caring for older adults focused on community participation focused on giving support to live with happiness and to die with human dignity. Family played the most important roles to provide basic care for older adults regarding basic needs, to give love, to make interpersonal relationships, and to nurture pride in older adults. Community leaders as mediators coordinate with health-care professionals in order to transfer health information and to encourage older adults to promote their health. Local administrative authorities supported local culture of activities for older adults to promote spiritual health in the community. A master plan for the sub district was suggested to guide the direction for community development for health care that is grounded in holistic principles and grounded in Thai cultural beliefs.

**Discussion:** The findings reflect the importance of community involvement that came from several parts in the community as community resources. These indicated that utilizing community resources to develop and to design healthcare model for older adults could be applied.

**Acknowledgements:** This research study was approved by the Naresuan University human ethic committee and assisted by a funding grant from the Naresuan University, Thailand.

**Becoming a Nurse: Caring and Humanity**
Kelsey Glubis, 3rd Year BScN student; Mentor: Dr. Colleen Maykut, Grant MacEwan University Bachelor of Science in Nursing Program, Edmonton, Alberta, Canada

As a nursing student, the magic and mystery of caring in my practice is the fact that it is still evolving. Utilizing Jean Watson’s theory of caring, which “describes a consciousness that allows nurses to raise new questions about what it means to be a nurse” (Perry, 2010, p. 267), has allowed me to gain a deeper understanding of what caring means to me.

Valuing human life, health, and love have become not only an important part of my practice, but have become staples in my personal life. I believe that basic human values are the basis of my caring ethos. This reflects Jean Watson’s theory of caring, which is a theory that encompasses the basics of human nature that are sometimes forgotten about on a daily basis.

This poster presentation reflects the journey of becoming a nurse, and how we must incorporate human values in our caring practice. Using the Disney animated movie Pinocchio as the theme for my poster, will represent how my paper and this movie correlate by focusing on human values that guide us in becoming what we are meant to be. While Pinocchio becomes a real boy who learns to love and care for others, I hope to become a “real” nurse, who continues to explore the magic and mystery of caring throughout my future career.

**Implementing Staff Caring Moment Board to Increase Nursing and Patient Satisfaction**
Jennifer Nack, RN, BSN (MSN student); Jennifer Walker, RN, BSN (MSN student); Mentor: Paola Buitrago, MSN, RN, CNML, WellStar Kennestone Hospital, Marietta, GA, USA

**Background:** It was recognized that as caregivers, nurses often forget to care for themselves. Staffing shortages, high acuity patients, and the ever changing United States healthcare system have helped lead to a stressful work environment in which can be physically, mentally, emotionally, and spiritually vigorous. It was recognized that as a cohort, staff needed to engage in self-care behaviors in efforts to reduce burnout and increase job satisfaction. After meeting Jean Watson at a research conference, two nurses were inspired to impact their units and assist nurses to engage in self-care activities through the implementation of a caring moment board.

**Methods:** Staff nurses, as part of a performance improvement initiative, created a “Caring Moment Board.” This is a bulletin board which features a new concept each month. The goal was for staff to be able to learn a self-care concept that would positively impact them. For example, the month of January featured positive affirmation cards that were pinned to the bulletin board. Staff would take an affirmation card they felt was something that inspired them, then they would leave an inspirational or positive quote of their own along with their name. At the end of every month, prior to the new board being put up, the participants would be entered into a drawing to win the caring moment pin they could place on their scrubs or badge to remind them the importance of self-care and self-love.

**Results:** It is believed that the implementation of this Caring Moment Program has led to increased nursing satisfaction. Nurses have provided positive feedback stating they “love coming into work to see the board. It really puts me at ease.” It was discovered that 85.19% of nursing staff reported feeling inspired from something seen on the caring moment board. In addition, 77.78% of nursing staff reported feeling as though the caring moment board contributes to their job satisfaction and 100% of the participants reported feeling as though someone at work cared about them.

**Conclusion:** Empowering nurses to engage in self-care activities both inside and outside the workplace contribute to nursing satisfaction and cohesiveness. When nurses use innovative tools, patients and staff both benefit
with better outcomes and nursing expands to reach the outer scope of its practice.

The Magic, Mystery and Miracles of Nursing Explored through Sister Simone Roach’s Six Cs of Caring

Tracy-Lee Anne Peterson, 4th year BScN; Mentor: Dr. Colleen Maykut, Grant MacEwan University Bachelor of Science in Nursing Program, Edmonton, Alberta, Canada

The main premise of Roach’s grand theory is based on philosophical-theological context, where she defines caring as a human mode of being (McCance, McKenna, & Boore, 1999, p. 1391). This is when individuals care because they are human, not because it is a part of their particular role, nursing for example (Roach, 2002, p. 38).

In order to explain this phenomenon, Sister M. Simone Roach considered what nurses were actually doing when they were caring. The main purpose of her work is to engage in the process of reflection and inquiry about caring as the human mode of being, through expression of virtuous acts to identify a person’s professional intention to care (Roach, 2002, p. 42). Through this analysis she developed the six Cs of caring: compassion, competence, confidence, conscience, commitment, and comportment. These elements provide a language of caring that can be universally understood (Bailey, 2009, p. 28).

The magic of nursing is not found in the ‘medical miracles’ reported in journals or newspapers, but is found in the simple, everyday things: how our mere presence provides comfort and healing. The magic of nursing is to see the human being behind the medical diagnosis, and treating each individual with consideration and dignity (Cheshire, 2011, p. 31). Through this universal understanding, I will bring to life the magic, mystery and miracles of caring through the use of six objects that symbolism Roach’s Cs of caring, and represent the magic of and within nursing.

A Human is a Human: Caring for the Impoverished and Disenfranchised

Meredith Porter, DipSW, 4th Year BScN; Mentor: Dr. Colleen Maykut, RN, BScN, MN, DNP, Grant MacEwan University Bachelor of Science in Nursing Program, Edmonton, Alberta, Canada

Caring for diverse populations is the essence of nursing. Because alterations in health are often unanticipated events (acute or chronic), registered nurses need to be aware of the needs and backgrounds of varied populations. Poverty is a global phenomenon; some estimates indicate that over one billion worldwide live in extreme poverty (Global Poverty Project, 2013), in Canada our national rate of poverty exceeds 10% (Canadians Without Poverty, 2013). Nurses, by virtue of number of registered professionals and their placement within the health care system, are ideally placed to demonstrate and model caring for this population. Part of this is the belief in miracle and magic—that people can be transformed and changed beyond what is predicted or commonly expected. Registered nurses are also well positioned to advocate for the redistribution of resources, from those who have them to those who need them. Ray’s Theory of Bureaucratic Caring will provide a grounded theory approach to conceptualizing the humanity of this population. Ray’s theory will then be used to extrapolate the individualized characteristics of registered nurses that are essential for effective engagement with individuals who are impoverished and disenfranchised. Further, the metaphor of “Robin Hood” will be used to discuss the necessity for reallocation and redistribution of wealth and resources when caring for this population. Presentation of this content will advance the science of caring.

Sleep Deprivation in Nurses: How Does it Impact Patient Care?

Kim Strong, student, BSN; Mentor, Dianne Kandt, MS, RN, CHPN, Roberts Wesleyan College, Rochester, NY, USA

Nursing is a science and an art that is practiced within the context of relationship, a caring relationship between a nurse and a patient. In order to provide authentic and safe care to the patient, the nurse needs to maintain healthy self-care habits. Adequate sleep is an important aspect of self-care that is often neglected. This project explores the prevalence of sleep deprivation in hospital-based nurses and how it affects safe nursing practice. The performance deficits resulting from sleep deprivation are discussed, as are the nursing tasks that are negatively affected by those performance deficits. Self-care suggestions are made for the nurse: methods to improve both quantity and quality of sleep, as well as methods of reducing fatigue and providing safer care to patients on the night shift. Suggestions for nursing management are also discussed: measures that can be incorporated into practice to support nurses, reduce the level of nurse fatigue, and thus enhance the safe care of patients.

The Magic, Mystery and Miracle of a Caring Relationship

Mallory van Dyke, 4th Year BScN student; Mentor: Dr. Colleen Maykut, Grant MacEwan University – Bachelor of Science in Nursing Program, Edmonton, Alberta, Canada

This poster is an aesthetic representation of my student nurse practice. My practice has been developing over the last three years and reflects acquired knowledge, skills, and attributes and experiential relationships with my patients. Competence is having the knowledge, judgment, skills, energy, experience, and motivation that are required to respond to the demands of a profession (Roach, 1992). Effective practice utilizes different sources of knowledge (Deltisidou, Gesouli-Voltryaki, Mastrogiannis, Mantzorou,
& Nougla, 2010). Intuitive, holistic, and theoretical forms of knowledge must be utilized to express the magic, mystery, and miracle of a caring relationship with another. A student nurse must incorporate all three aspects of knowledge to care for his/her patient effectively and safely.

The Magic within a Nurse-Client Connection
Juliet Williams, BScN 4th year student; Mentor: Colleen Maykut, BScN, MN, DNP, RN, Grant MacEwan University Bachelor of Science in Nursing Program, Edmonton, Alberta, Canada

A therapeutic nurse-client relationship has a life-giving quality that is magical and comes alive within the nurse-client connection. Halldorsdottir’s nursing theory of the life-giving nurse describes this connection as a bond of energy similar to a bridge that is formed between the nurse and client during care. A life-giving nurse is enabled by genuine connection, honest communication, and trust. This connection and sense of trust is essential for a therapeutic relationship to develop in order to improve health outcomes. The magic of nursing is the art of caring: what nurses do and how these acts are experienced by clients and families. My clinical experiences as a nursing student, in addition to current research, have revealed that the expression of professional love is important to the practice of nursing. When love is present, the prospect of health rises and quality of life improves. The ultimate goal of all nurse-patient relationships is to attain a connection that promotes health through meaningful, genuine communication and interaction.

Caring for Adults with Developmental Disabilities in the Hospital Setting
Sara Wood, BSN student; Mentor: Dianne Kandt, MS, RN, CHPN, Roberts Wesleyan College, Rochester, NY, USA

Statistics show that individuals with developmental disabilities are living longer than in past decades, have complicated medical histories, and are more likely than the general population to be hospitalized numerous times throughout their lives. Current literature also suggests that a lack of knowledge among nurses about how to care for and communicate with adults with developmental disabilities has resulted in negative attitudes, stigmatization, and marginalization regarding this population in the hospital setting. Researchers have examined the dynamics of nurse-patient relationships, whether or not nurses view time as a barrier to communication, how nurses approach health education, and how people pursue questions to adults with developmental disabilities in an attempt to explain why this population is three times more likely than the general population to experience preventable and adverse events when hospitalized. Despite the current research identifying probable causes, there remains a lack of research providing solutions to this problem.

For this nursing impact project, a review of the current literature was completed and several interviews were conducted with registered nurses working in a hospital setting and for an agency that provides comprehensive services for adults with developmental disabilities. Several common themes emerged from this research that suggested possible ways to improve the quality of care provided to adults with developmental disabilities in the hospital setting. The two major themes that emerged include the need to clearly define and delineate between the roles and responsibilities of caregivers, family members, and nurses in the hospital setting and the need to provide nurses with education regarding specific communication techniques that can be used to improve communication between nurses and individuals with various cognitive abilities.

The findings of this project suggest that by clarifying roles, educating nurses, and improving communication between nurses and adults with developmental disabilities, the quality of care provided to this patient population will improve, the frequency of preventable and adverse events will decrease, and nurses will be less likely to stigmatize or marginalize this patient population. Nursing theorist Sister M. Simone Roach identified six ways in which nurses can demonstrate caring, and the results of this project support this theory by suggesting that clarifying roles and providing additional education about communicating with adults with developmental disabilities enables nurses to be increasingly competent, compassionate, and confident in the care they provide to this patient population. In the future, solutions presented in this project may be used to develop solutions for providing high quality nursing care to other challenging patient populations.

Mothers of Newborns: Help Seeking Behavior as Calls for Caring
Mary Ellen Wright, MSN, APRN, CPNP, Doctoral Student, Florida Atlantic University, Boca Raton, FL, USA, Mission Health – Nurse Researcher Women’s and Children’s Health

Introduction: Help-seeking behavior is the act of searching for assistance to fulfill a need. Help-seeking involves identification of the problem the person is looking to solve or improve upon, the intentional act of pursuing help and the interaction with a third party from which help is sought. The help-seeking process is a call for caring and the introduction of a nursing situation. A nursing situation is a shared lived experience in which the caring between the nurse and the person(s) being nursed enhances personhood. The purpose of this presentation is to present an exploratory study of help seeking behaviors of mothers in the first weeks and months after having a baby. Sources of support for
women experiencing motherhood in the early postpartum period vary in the United States and include formalized health care professionals, individual social networks and more recently, electronic media. Nurse caring to address the support needs of women in the early postpartum period will be enhanced by understanding the help-seeking behaviors of mothers with an infant.

**Methods:** This theory-guided pilot study used an exploratory descriptive survey design. An internet survey using a new mothers support network resulted in a population of 242 respondent mothers in the first 6 months postpartum, with the final respondents (N = 219) that met inclusion criteria.

**Results:** The population demographics include: age range from 19 to 41 years; first babies (67%); race categories: Caucasian (87.7%), African American (2.7%), Pacific Islander (0.5%), American Indian or Alaska Native (0.9%), reported mixed race or other (9.6%); Education: 88.6% attended college or earned a college degree; Socioeconomic class: self-reported 12.8% upper class, 70.8% middle class, and 15.7% below middle class. The sources of baby care information that the mothers currently use include internet (94.1%), the participant's mother (76.3%), books (74.9%), pediatric office (68.0%), friends (62.6%), as the highest percents. Mothers identified the following as preferred sources of information on baby care: Internet (74.4%), Baby's Doctor's Office (72.1%), and with 44.7% wanting to be able to call a nurse. Other sources of information are described in the study identifying current use and preference.

**Implications:** In order to develop caring opportunities between nurses and mothers of newborns, help-seeking patterns of behavior need to be identified. The limitations of this study were the use of a homogenous population and use of the internet only surveying method. A current survey is underway with a heterogenous population. Further research is needed as to the help-seeking behaviors from a variety of populations in order to develop caring strategies to support mothers in the care of their infants and themselves.
第35回
国際ヒューマンケアリング学会

テーマ
ケアリングの普遍性
The Universality of Caring

会期 Dates
2014年5月24日（土）～28日（水）
May 24 (Sat.) ～ 28 (Wed.), 2014

会場 Venue
国立京都国際会館
Kyoto International Conference Center
Kyoto, Japan

共同会長 Co-Chairs
法橋 尚宏
神戸大学医学部保健学研究科
Kobe University Graduate School of Health Sciences

マリアン・C・ターケル
アイシェイトイン医療ネットワーク
Marian C. Tarkel, PhD, RN, NEA-BC, FAAN, President of the International Association for Human Caring
Einstein Healthcare Network

トランスカルチャー看護とケアリング分科会
SIG on Transcultural Nursing and Caring
テーマ：東西のトランスカルチャー看護学
Theme: Transcultural Nursing, East and West

共同会長：石崎 和子（石崎病院看護大学）、法橋 尚宏（神戸大学医学部保健学研究科）
Co-Chairs: Kazuko Ishigaki, PhD, RN, PHN (Nakahara Prefectural Nursing University)
                                  Naohiro Hohashi, PhD, RN, PHN, LSN (Kobe University Graduate School of Health Sciences)

2014 Kyoto, Japan

学術集会Webサイト Conference web site
http://www.humancaering.jp/35iahcc/
学会Webサイト Organization web site
http://www.humancaering.org/

神戸大学大学院保健学研究科
Division of Family Health Care Nursing,
Kobe University Graduate School of Health Sciences

7-10-2 Tomogaoka, Suma-ku, Kobe, Hyogo 654-0142, Japan

学術集会Webサイト Conference web site
http://www.humancaering.jp/35iahcc/
学会Webサイト Organization web site
http://www.humancaering.org/
Dear Colleague:

The International Association for Human Caring (IAHC) is dedicated to the advancement of the body of knowledge of caring and caring research within the discipline of nursing. IAHC seeks to support nurse scholars world-wide to investigate care and caring and to share these findings with colleagues. In line with its mission, IAHC currently supports nurse researchers and students.

The IAHC could not meet its goals without the support of its membership. Continued support of membership is crucial to meet new challenges in order to provide additional student scholarships and scholar awards. Please consider contributing to these efforts through the IAHC. All donations, large or small, are welcomed and do make a difference. Your gift will be used to support research and scholarship. All donations are tax deductible.

Sincerely,

President
Marian Turkel, PhD, RN, NEA-BC

Chair, Fundraising Committee

Name ___________________________ Donation Amount ________________________

PAYMENT TYPE

_______ Check Enclosed (Make payable to International Association for Human Caring)

_______ Credit Card (Circle one: VISA MC DISCOVER)

Credit Card # ___________________________ Expiration Date ________________________

Signature ___________________________

Advertising Rates

<table>
<thead>
<tr>
<th>Sponsor</th>
<th>$4,000</th>
<th>Logo and Name on the inside Title page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full page</td>
<td>$2,000</td>
<td>Camera-ready copy, 7” x 10”</td>
</tr>
<tr>
<td>Half page</td>
<td>$1,000</td>
<td>Camera-ready copy, 3.25” x 5”</td>
</tr>
<tr>
<td>Quarter page</td>
<td>$500</td>
<td>Camera-ready copy, 2.25” x 3.25”</td>
</tr>
</tbody>
</table>

Company/Institution:

__________________________________________________________

Name: ___________________________________________________

Credentials: _______________________________________________

Address: __________________________________________________

City: ___________________________ State/Province: ____________ Zip: ____________

Country: __________________________________________________

Advertising size: __________________ Advertising fee: ________________

Make check payable to International Association for Human Caring

MAIL DONATIONS AND ADVERTISING COSTS TO

International Association for Human Caring
Professional Nursing Resources, Inc.
801 East Park Drive, Suite 100
Harrisburg, PA 17111 USA
International Journal for Human Caring Subscription

The International Journal for Human Caring is published four times annually.

Individual Subscription (1 year (4 issues)):     ___ U.S. - $80     ___ Canada - $90     ___ International - $96
Institution Subscription (1 year (4 issues)):  ___ U.S. - $130   ___ Canada - $140   ___ International - $146

Name:_________________________________________ Credits:____________________
Address:_____________________________________
City:_________________________________ State/Province:___________ Zip:__________
Country:____________________________

Make checks payable (US currency only) to: International Journal for Human Caring
Mail to:        801 East Park Drive, Suite 100, Harrisburg, PA 17111

Credit Card (circle one):                 Visa                                    MasterCard                                          Discover
Credit Card Number: ___________________________ Expiration Date: (month) ____ (year) ____
Signature:________________________
Print name as it appears on the credit card:

Visit online @ www.pronursingresources.com        Phone: 717-703-0033    Fax: 717-234-6798

Interested in Membership in the International Association for Human Caring?

Benefits of Membership:
- Subscription to International Journal for Human Caring
- Annual conferences; discounts for conference registration
- Voting; nominating privileges
- Newsletters
- Networking

Annual Dues:
- Regular membership - $100 (High income country); $40 (Middle income country; $20 (Low income country)
- Student/Retiree - $50 (High income country); Middle and Low income countries pay individual rate
- Institutional - $350 (High income country); $140 (Middle income country); $70 (Low income country):
  5 voting members; 5 journal subscriptions
- Individual Lifetime - $2000 (High income country); Middle and Low income countries’ rates obtained from
  aleta@pronursingresources.com

Make checks payable:    International Association for Human Caring    Phone: 717-703-0033
(US dollars only) 801 East Park Drive, Suite100    Fax: 717-234-6798
Harrisburg, PA 17111    www.pronursingresources.com
USA

Name:_________________________________________ Credentials:____________________
Address:_____________________________________
City:_________________________________ State/Province:___________ Zip:__________ Country:____________________
Membership type:________________________ Membership fee:________________________
Credit Card (circle one):                 Visa                                    MasterCard                                          Discover
Credit Card Number: ___________________________ Expiration Date: (month) ____ (year) ____
Signature:________________________
Print name as it appears on the credit card:
Care/Caring Words

The cover of the International Journal for Human Caring was designed by May Troung in consultation with members of the Editorial Advisory and the Editorial Review Boards of the journal, along with other colleagues. Together we provided the words that represent care and caring in different languages. We hope that more words are submitted so that we can add such words to the cover.

Danish: omsorg and/or pleje
French: le caring
Thai: caring is EUA-AR-THORN
Persian: محبت
German: PFLEGE
Turkish: BAKIM
Spanish: caring is cuidado
Tagalog (Philippine): PAG-AARUGA
Swedish: caring is vårdandet and omvårdnad
Finnish: caring is hoitaminen
Portuguese: caring is carinho
Hungarian: care is gondviseles
Chinese: care and caring are:

『關心』 (Taiwan usage)
『關心』 (China usage)

Kiswahili - (Congo, Kenya, Tanzania) - KUJALI
Ichibemba - (Zambia) - UKUTANGATA