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A caring model for nursing education

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Abstract: With the many changes occurring within the health system and nursing education, ongoing shortages in the number of nurses and nursing faculty, increased incidences of incivility, and the charge to transform nursing education while upholding and transmitting the core professional values, a better understanding of the climate within nursing education is warranted. Caring is a core value of the profession of nursing and has received much attention and study, primarily in the practice setting. In nursing education much of this work has centered on the structure and processes of nursing education and the nursing student's development of caring behaviors. This article proposes a caring model for nursing education that integrates the key concepts of organizational climate, leadership, and caring theories. The intent of the model is to provide a framework that can be used for professional nursing education that incorporates the core value of caring and develops graduates prepared to provide relationship-based, patient-centered care.

Keywords: caring ability; caring climate; caring model; nursing education.

Caring is a core value of the nursing profession and has received much attention and study, primarily in the practice setting. In nursing education much of this work has centered on the structure and processes of nursing education and the nursing student's development of caring behaviors. With the many changes occurring within the health system and nursing education, ongoing shortages in the number of nurses and nursing faculty, increased incidences of incivility, and the charge to transform nursing education while upholding and transmitting core professional values (Benner, Sutphen, Lenonard, & Day, 2010, p. 2), a better understanding of the climate within nursing education is warranted. The purpose of this article is to present a caring model developed by the authors for nursing education that integrates the key concepts of organizational climate, leadership, and caring theories. The intent of the model is to provide a framework that can be used for programs to create an environment for professional nursing education that incorporates the core value of caring and develops graduates prepared to provide relationship-based, patient-centered care.

Contributing theories

The theories contributing to the development of this model are organizational climate, leadership, and caring. Major concepts from these theories are reflected in the framework.

Organizational climate theories

Organizational climate refers to individual and group perceptions, reactions, and behaviors of the environment (Schneider, Ehrhart, & Macey, 2013). Often confused with the concept of culture, researchers differentiate organizational culture from climate according to the organizational level, more specifically, where culture is

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more closely associated with the macro level of the organization; namely "how we do things around here," the icons, history, and traditions.

Historically, climate theories reflected three types of approaches to the conceptual and operational definition of organizational climate: (a) the multiple measurement-organizational attribute, (b) the perceptual measurement-organizational attribute approach, and (c) the perceptual measurement-individual attribute approach (Bastien, McPhee, & Bolton, 1995). Organizational climate is the term used to describe the shared meaning attached to the interrelated bundle of experiences and perceptions of the organizational environment by individuals within the environment (Schneider et al., 2013). The organization's environment is comprised of the formal structures and the leadership of an organization. Individual attributes include the person's abilities, behaviors, and perceptions. The dynamic interaction between and among the organization's structures, leaders, and individuals comprises the third category of elements that contribute to organizational climate (Schneider et al., 2013).

Two areas of focus that have implications for a caring model in schools of nursing are an ethical climate and an inclusive climate. An ethical climate is an environment that supports the investigation and resolution of decisions involving ethical issues. Employees interact within an ethical climate through formal and informal socialization processes and events. It is believed to manifest the values of the organization and is considered a characteristic of a healthy work environment (Suhonen, Stolt, Katajisto, Charalambous, & Olson, 2015). In a review of studies focused on ethical climates in 44 nursing organizations (where only one was a school of nursing), Koskenvuori, Numminen, and Suhonen (2019) identified an association among job satisfaction and organizations having ethical climates that demonstrated caring, collaboration, organizational support, and opinions about work and ability to manage disagreements.

Inclusive climate research examines the impact of organizational climates that address diversity, sensitivity to individual values and preferences, and the effect of culture on organizational effectiveness including client outcomes, client and staff satisfaction, and staff performance. Where the climate is perceived as being engaging and inclusive, staff feels empowered and energized to complete the work and may be motivated to be innovative (Hannah, Sumanth, Lester, & Cavarretta, 2014). A scarcity of research exists about inclusive climates in schools of nursing.

Leadership theories

Studies have consistently indicated that leadership significantly impacts organizational climate (Cogaltay & Karadag, 2016; Hoffmans, 2006; Mosser, 2000; Schneider et al., 2013). The concept of leadership encompasses (a) the attributes of the individuals and the manifestation of these attributes in behaviors; (b) the structure and processes such as the organizational chart, policies, and procedures found within organizations; and (c) the purposes of leadership, the accomplishment of the mission and goals of the organization (Van Wart, 2013).

A review of contemporary leadership theories identified six major classifications: classic, transactional, transformational, horizontal or collaborative, ethical, and critical leadership theory (Van Wart, 2013). Other current leadership literature use the leadership labels of shared leadership, adaptive, aesthetic, spiritual, character-based, authentic, and servant leadership (Hannah et al., 2014; Koskenvuori et al., 2019; Sousa & van Dierendonck, 2017; Van Wert, 2013). Regardless of what level, lens, or dimension of leadership being examined, common elements have remained the same.

Ethical leadership theory and other leadership models such as values-based, spiritual, aesthetic, and character-based, emphasize values focused on integrity and intent of the leader (Hannah et al., 2014). The moral implications of ethical leadership impact a caring environment by building trust with employees and communicating and demonstrating an intention to do what is right, doing what is right, and achieving a good outcome for the customer, the organization, and the employee (Koskenvuori et al., 2019; Van Wart, 2013).

Caring theories

Since the late 1970s, several nurse theorists have developed theories of caring that have been tested and applied in both practice and education. One of the most well-known caring theories is Watson's Theory of Human Caring (2009). Originally published in 1979, the theory describes 10 carative factors and identifies the key concepts of caring, with a focus on clinical practice where the nurse provides relationship-based, patient-centered care in the healthcare setting (Watson, 2009; Watson, 2011).

Building on Watson's Theory of Human Caring, Swanson (1991) developed a middle range theory of caring framed by five caring processes: *knowing*, *being with (presence)*, *doing for*, *enabling*, and *maintaining belief* (Swanson, 1991). This theory expanded the understanding of caring and processes within the nurse-patient relationship.

Leininger's theory of Culture Care Diversity and Universality and the associated Sunrise Model provided another major contribution to caring theories. Although originally published as a theory in 1991, it evolved from Leininger's anthropological work of the early 1960s (Leininger, 1991). Essential tenets of this theory include the central focus and essence of nursing as care and caring as essential for health and healing. Development of this theory has resulted in understanding that culturally congruent nursing care considers one's worldview and seven cultural and social structure dimensions evidenced in the Sunrise Model (Leininger, 1991; Leininger, 2001). As in the Watson and Swanson theories, the emphasis is on the nurse-patient relationship.

The Theory of Bureaucratic Caring was initially formulated in the early 1980s through qualitative research in a hospital setting (Ray, 2018). It included two key concepts: bureaucratic caring and spiritual-ethical caring. Seven dimensions surround the central concept of spiritual-ethical caring. These dimensions are social-cultural, educational, physical, political, economic, legal, and technological (Ray, 2018). Since that time, Ray's work has been used to guide research in nursing administration and education.

Boykin and Schoenhofer (2020) originally proposed the Theory of Nursing as Caring in the early 1990s following faculty work on curriculum revision for a caring-based curriculum. It is built on six assumptions with nine key themes: caring, focus and intent of nursing, nursing situation, personhood, direct invitation, call for nursing, nursing response, caring between the nurse and one cared for, and the dance of caring persons (Boykin & Schoenhofer 2020). The theory has been used to guide research in nursing practice, administration, and education.

With the advances in technology in health care, it has become most important that the central focus of caring be maintained in nursing. Locsin's Technological Competency as Caring in Nursing builds on Boykin's and Schoenhofer's (2020) theory. It provides a framework whereby competency in technology is viewed as caring, wherein the nurse will know the individual as a whole person and that person will remain the focus of care (Locsin, 2020). While this model was developed primarily for use in the practice arena, it is becoming equally important in nursing education as the teaching-learning process frequently occurs in a virtual environment.

The earliest work on caring in nursing education was perhaps the work of Bevis and Watson (1989). It was first conceptualized as a new paradigm for nursing education in 1989 and subsequently reproduced in 2000 when Bevis (1989a) determined there was a "need for change in the curriculum development paradigm" (p. 15) from a Tyler model and behaviorism, a model described by Watson (1989a) as "out of step with transformative education and nursing as a human science" (p. 30), to a paradigm that was more humanistic and caring. Watson (1989b) proposed that the new paradigm of transformative education provided for the acknowledgment that teaching-learning was "a distinctively human process and activity" (p. 52). The key ingredient of this paradigm is the role of the teacher where the transactions and interactions between teachers and students constitutes the curriculum (Bevis, 1989b, p. 153).

Since Bevis and Watson's early work with caring (1989), there has been an increased application of other models specifically to nursing education. In 2004, Parse expanded her theory of human becoming to reflect a new paradigm of teaching-learning. Basic concepts included "essences, paradoxes, and processes" (Parse,

2004, p. 34). Each of these concepts is further defined with three to six more specific sub-concepts, and teaching-learning is viewed as a "never ending journey of coming-to-know" (p. 35).

More recently, a new model and a new theory for care in nursing education have emerged: Chamberlain Care (Groenwald, 2018) and We Can Be More Caring (Monsen, Le, Handler, & Dean, 2017). The Chamberlain Care model represents a holistic education model consisting of six circles. At the heart of the model is care of self. The next three circles represent care of colleagues, care of students, and care of patients and families. The outer two circles represent the environment and healthcare transformation in which graduates bring "values that help transform healthcare worldwide" (Groenwald, 2018, p. 10).

The We Can Be More Caring theory was developed using a grounded theory approach when the researchers discovered there was no framework for developing caring in nursing students. Major concepts of the theory include (a) vulnerability, (b) cultural immersion, (c) service learning, and (d) caring" (Monsen et al., 2017, p. 10). Based upon data from student interviews, 10 steps were identified, resulting in students being more caring. Six of these steps were specifically identified as aligned with Parse's theory. Benner's (1982), Leininger's (1991), and Watson's (2009) theories also aligned with the various steps of the process.

This overview of organizational climate, leadership, and caring theories in nursing indicates that caring is a complex phenomenon that includes antecedents as well as attributes for caring to occur (Finfgeld-Connett, 2008). Antecedents include the individuals in the relationship and a supportive environment. Within this relationship are the knowledge of self and others, courage, respect, openness, and patience which contribute to the individual's ability to care (Nkongho, 2008). The environment where caring occurs is comprised of the non-individual attributes of the system. Structures, such as the mission, vision, values, curriculum, policies, and procedures, define behavior norms within an organization. Similarly, processes established by the leaders in the organization enhance caring by demonstrating the value of individuals, reducing work-related stress, and allocating sufficient time for cooperation and collaboration (Finfgeld-Connett, 2008). A supportive environment perceived by faculty and students within a school of nursing endorses and affirms caring behaviors.

Attributes of caring are individual abilities, perceptions, and behaviors including being physically and mindfully present, being emotionally open and available, listening attentively, maintaining eye contact, appropriate touching, providing verbal reassurances, being respectful, and being culturally aware. Caring outcomes include physical and mental well-being for the recipient and mental well-being for the nurse (Finfgeld-Connett, 2008). Based on findings from Finfgeld-Connett's meta-synthesis of caring in nursing, the authors posit that in a caring relationship between faculty and students, faculty must know themselves as well as the students, respect the individuality of each student, have courage to enter into that relationship, be open to the reciprocal nature of an intimate relationship, demonstrate patience, and be present in order to listen and ensure effective communication.

Caring model for nursing education

Major concepts in the proposed model include (a) school of nursing climate, (b) structural characteristics, (c) individual affective characteristics, (d) interactions/relationships, (e) caring nurse graduates, and (f) relationship-based, patient-centered care. Sub-concepts within structural characteristics include (a) leadership, (b) standards, and (c) curriculum. Sub-concepts within individual affective characteristics encompass (a) ability to care, (b) caring behaviors, and (c) perception of caring (see Figure 1).

School of nursing climate

The school of nursing climate is a sustainable shared group phenomenon, based on the pattern of individual experiences in school life. Furthermore, it reflects the dynamics of organizational structures, relationships, and individual abilities and perceptions. A caring school of nursing climate is a positive phenomenon experienced by individuals and shared by groups within the school of nursing.

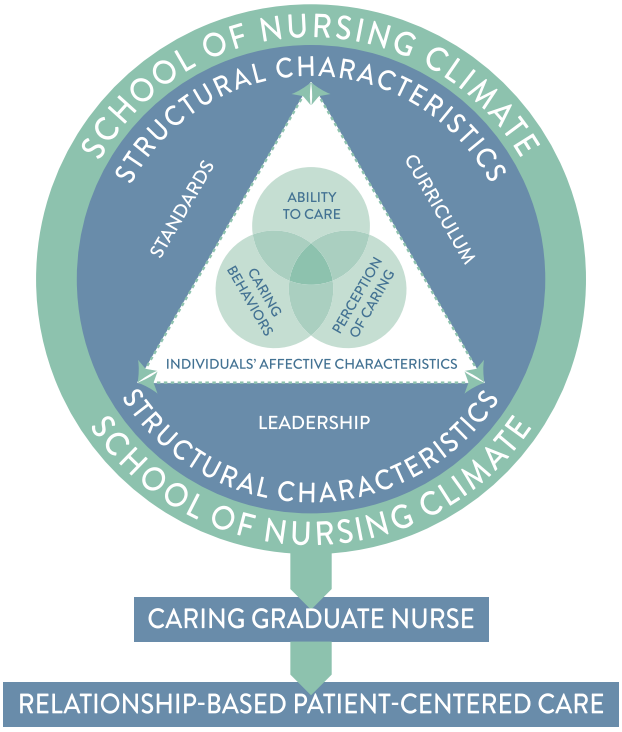

Figure 1: Caring model for nursing education.

Structural characteristics

The structural characteristics in this model include (a) leadership, (b) standards, and (c) curriculum (Grigsby, 1991), and reflect the environmental elements found in the organizational climate literature. Structural characteristics define and constrain expectations and behaviors of groups and individuals within the organization.

Leadership

In the model of a caring climate in schools of nursing, the authors incorporated concepts from leadership literature, including the structure of the organization which may be hierarchical and controlled, or decentralized and stakeholder-driven. The bureaucracy of an organization may determine the extent to which policies and procedures rigidly control all aspects of organizational life and, thus, the degree to which people feel "cared for." The relationship between leader attributes and organizational structure impacts the characteristics and abilities of the individuals involved, the interactions that occur, and the environment or context where interactions happen.

A leader's willingness to share power acknowledges the strength of employees and contributes to a caring climate (Owens & Hekman, 2016; Sousa & van Dierendonck, 2017; Wang, Owen, Junchao, & Lihua, 2018). In servant leadership, horizontal, shared, or leader-member exchange models, collaborative leaders recognize their own limitations and the necessity of achieving organizational objectives through teams and shared decision-making. For shared decision-making to occur, leaders allow sufficient time for input and collaboration. Employees feel "cared for," less stressed, and valued because the leader seeks their input. Recognition of the employee's expertise also demonstrates a valuing of the employee when given the independence to make decisions and implement actions (Van Wert, 2013).

The dean's or director's power, leadership style, and treatment of faculty contribute to the climate within schools of nursing and to the extent to which the climate is a caring one. Leadership and competence of faculty with supervisory or coordinating responsibilities also directly impact organizational climate and effectiveness within the school. Where there is a trusted relationship between the leader and follower, as in ethical leadership, satisfaction, performance, and freedom in expressing opinions flourish, all necessary for a caring climate (Dull, 2009).

Standards

Standards as a structural characteristic consist of foundational professional and accrediting organization standards. Foundational professional statements include the American Nurses Association (ANA) social policy statement (2010) and standards of practice (ANA, 2015), Quality and Safety Education for Nurses (QSEN) competencies (QSEN Institute, 2019), and the National League for Nursing (NLN) core competencies for the academic educator (Halstead, 2019). ANA's social policy statement describes the caring contract that nursing has with society (2010). The standards of practice foundational document, *Nursing: Scope and Standards of Practice* (2015), identifies the tenets of nursing practice: "(a) nursing practice is individualized and (b) caring … is central to the practice of the registered nurse" (pp. 7–8). The QSEN project identified patient-centered care as one of six competencies to improve patient care and the health care environment (QSEN_Institute_2019).

The third professional standard foundational to the model is the NLN core competencies for the academic nurse educator (Halstead, 2019). The concept of caring is addressed in Competency I which describes the behavior of using caring to facilitate learning (Caputi & Frank, 2019) and Competency VIII which indicates the need for the educator to integrate caring in the development of faculty and students (Krouse & Fox, 2019).

Accreditation standards for schools of nursing also endorse the concept of caring. For example, the AACN emphasizes patient-centered care and the core nursing values of human dignity, integrity, autonomy, altruism, and social justice (AACN, 2008). These professional standards are required of all undergraduate programs seeking accreditation from the Commission on Collegiate Nursing Education (CCNE, 2018, pp. 6, 13). The National League for Nursing Commission for Nursing Education Accreditation (CNEA) accreditation standards are founded on the NLN core values of caring, diversity, integrity, and excellence (NLN CNEA, 2016). Additionally, caring is specifically addressed in Standards 3 and 4 which focus on a culture of excellence in the care of faculty and students.

Curriculum

The curriculum contributes to the climate in schools of nursing, especially the teaching-learning environment (Brown, 2011; Lewis, Rogers, & Naef, 2006). Although curriculum is traditionally viewed as courses and sequencing of the courses, core ingredients of a caring curriculum include modeling of caring behaviors, day-to-day experiences (by faculty and students), authentic dialogue, and confirmation or affirmation in the faculty-student relationship (Hills & Watson, 2011; Murray, 1989; Watson, 1989b). The beliefs and attitudes of the faculty are considered essential to instilling the value of caring in students. Reports on the implementation of a caring curriculum or a value-based curriculum indicate the importance of faculty understanding and embracing the value of caring. Emphasis is also placed on faculty being provided with the skills as well as the knowledge about caring (Lee-Hsieh, Kuo, & Tsai, 2004; Lee-Hsieh, Kuo, Turton, Hsu, & Chu, 2007; McLean, 2012).

Implementation of a caring curriculum includes the use of effective teaching strategies. Deliberate caring teaching strategies include creating opportunities for students and faculty to know each other as persons and engaging the student and educator as co-partners through dialogue and reflection. Creating student and educator understanding of the mutual responsibility to nurture each other as well as self-knowing are also important philosophies guiding the learning experiences (Dewar & Nolan, 2013; Fahrenwald et al., 2005; Graber et al., 2012.). Teaching strategies can include a specific course on caring, clinical experiences, the use of caring groups, storytelling, case study, role play, immersion, service learning, and reflection to teach caring or

a related concept such as empathy or "presence" (Adamson & Dewar, 2015; Brunero, Lamont,& Coates, 2010; Hughes, Kosowski, Grams, & Wilson, 1998; Kuntarti, Yetti, & Novieastari, 2018; LaRocco, 2010; Ozcan, Oflaz, & Bakir, 2012; Pullen, Murray, & McGee, 2001; Richardson, Percy, & Hughes, 2015; Sanders, 2016).

Individual affective characteristics

The affective characteristics in the model are (a) the ability to care, (b) caring behaviors, and (c) perceptions of caring by the individual being cared for. As indicated by the triangle, these three concepts are inter-related and linked for both faculty and students. Foundational to the model is the belief that the ability to care can be taught and acquired. Caring behaviors are described consistently across the literature, and faculty and students report being cared for as a result of perceiving the caring behaviors (Beck, 2001). The cultural values and beliefs of the individual also influence perceptions of caring.

Ability to care

The affective characteristic of the ability of an individual to care is a complex phenomenon determined by both internal personal attributes and experiential and situational variables. Internal personal attributes include maturity, cultural influences, and insight into self. The ability to care also requires personal courage in order to risk exposing oneself to another. Other personal attributes that determine the ability to care are tolerance and persistence (Nkongho, 2008). Being "cared for" or experiencing help from another can impact a person's ability to care (Beck, 2001). The organization facilitates the ability to care by clarifying expectations of behaviors in policies and procedures and interaction with others in the environment. As a result of this facilitation, the ability to care exists on a continuum and can change over time (Grilo, Santos, Rita, & Gomes, 2014; Loke, Lee, Lee, & Noor, 2015; Murphy, Jones, Edwards, James, & Mayer, 2009; Sandvik, Eriksson, & Hill, 2014; Simmons & Cavanaugh, 1996; Wu, Chin, & Chen, 2009).

Caring behaviors

Behaviors that demonstrate caring are (a) physical and non-physical and (b) verbal and nonverbal. Physical demonstrations of caring vary with cultural influences. For example, in some cultures, caring may be demonstrated by eye contact and active listening while in other cultures these behaviors may not be perceived as caring. Likewise, culture impacts how various forms of touch communicate caring such as hugs, hand holding, or sitting close to someone or how these same behaviors may be considered culturally inappropriate. Physically assisting someone or working together as a team also demonstrates caring (Leininger, 2001; Watson, 2011).

Non-physical behaviors may also communicate support and concern. These behaviors include demonstrating respect and trust, being open to honest dialogue and feedback, as well as providing verbal reassurance, education, and encouragement (Swanson, 1991). Other behaviors, such as taking the time to sit with someone, could be considered both physical and nonphysical.

Perception of caring

Individuals perceive caring in a variety of ways due to its individual nature and cultural influence. As each individual is unique, so are emotions, feelings, and reactions to external stimuli from the environment, experiences, and other individuals. A person perceives caring when another indicates an understanding of that person's cultural preferences and practices. The perception of caring comes when one respects the uniqueness, rights, and dignity of the individual, values his or her contributions to a team effort, and is concerned with the individual's well-being. Likewise, an individual can perceive being cared for when assisted with a mental or physical task, trusted, or supported during a difficult experience (Brett, Branstetter, &

Wagner, 2014; Grigsby & Megel, 1995; Labrague, McEnroe-Petitte, Papthanasiou, Edet, & Arulappan, 2015; Mlinar, 2010).

Interaction/relationships

The authors posit that the model is dynamic and reflects interactions between and among the various concepts. The outer circle represents the environment in which teaching/learning occurs. It encompasses all the structural and process components within the model. Research indicates that the degree to which the climate reflects caring and organizational support and addresses diversity and sensitivity influences faculty engagement, job satisfaction, retention, overall performance, and meaning found in work, as well as contributes to a healthy work environment (Lee, Miller, Kippenbrock, Rosen, & Emory, 2017). The degree to which the climate is caring can (a) impact student well-being, self-confidence, anxiety, motivation, and learning (Arrigoni et al., 2017); (b) predict students and graduates' caring ability (Simmons & Cavanaugh, 1996, 2000); and (c) affect the students' ability to learn to care (Labrague et al., 2016). The interaction of concepts is demonstrated in the findings from a study by Hayne, Schlosser, and McDaniel (2019) indicating a difference in caring climates based on school type, while Phillips, Fillmore, O'Lynn, Bassell, & Hollinger-Smith (2018) noted a positive shift in the school of nursing climate and faculty engagement following implementation of the Chamberlain Care model.

The inner circle, structural characteristics, is comprised of leadership, standards, and the curriculum. The interaction of the leader is an especially important determinant of climate. Transformational and servant leadership are significant predictors of a positive climate (Schneider et al., 2013). The behaviors of the leaders with faculty, staff, and students have a large effect on job satisfaction (Cogaltay & Karadag, 2016; Lee et al., 2017), sense of trust and justice (Cogaltay & Karadag, 2016), and faculty retention (Lee et al., 2017). Implications for nurse administrators included the following: lead by example, demonstrate caring behaviors, provide new faculty orientation and faculty development in an effort to advocate for student care and support, include caring items on course evaluations (Fifer, 2019), tailor personal and family policies to faculty needs, provide support, and communicate expectations clearly (Lee et al., 2017).

Professional standards have a significant impact on the curriculum, especially in guiding the content to be addressed and faculty expectations. The centrality of caring to nursing is clearly delineated in the ANA's social policy statement (2010) and standards of practice (2015), as well as accreditation standards, thus indicating a need for inclusion in the curriculum. The NLN core competencies for academic educators address the expected behavior of caring and how it affects learning and the organizational climate, while the QSEN core competencies address patient-centered care.

In the model, curriculum refers to a series of courses with specific objectives, content, and learning experiences. Inherent in this definition are the faculty, faculty-student relationships, and a belief that caring can be learned. Numerous publications reflect characteristics and behaviors of effective faculty which are discussed later in the section on caring behaviors. As courses are developed, it is important to introduce caring concepts in the earlier courses, while providing reinforcement throughout the program (Labrague et al., 2016), and selecting learning experiences which enable students to individually develop these skills.

The triangle within the inner circle identifies the individual affective characteristics pertinent to the development of a caring climate in the school of nursing: (a) ability to care, (b) caring behaviors, and (c) perceptions of caring. The Venn diagram is used to illustrate the interconnectedness of these three characteristics.

The authors propose that one's ability to care is influenced by multiple factors, a belief supported by other researchers. Although findings from one national study indicated there was no difference in faculty caring ability across various educational settings (Hayne et al., 2019), findings from a focus group with nursing students indicated that students identified parents as the first individuals to effect caring development followed by peers, lecturers [faculty], senior students, graduates, and patients (Kuntarti et al., 2018).

Caring behaviors are also representative of effective teacher characteristics. The behaviors include being organized, encouraging, supportive, prepared, respectful, attentive listeners, flexible, and trusted (Fifer, 2019;

Gignac-Caille & Oermann, 2001; Labrague et al., 2016). These caring behaviors have been found to have an effect on students' behavior (Labrague et al., 2016), students' learning (Gignac-Caille & Oermann, 2001), student role transition (Arrigoni et al., 2017), caring ability (Simmons & Cavanaugh, 2000), and students' self-efficacy (Fifer, 2019).

As noted, the authors propose that perceptions of caring are individualized and affected by multiple factors. While data are more limited for faculty perceptions, recent studies address the perceptions of nursing students regarding faculty caring (Arrigoni et al., 2017; Fifer, 2019; Henderson, Sewell, & Wei, 2020; Labrague et al., 2016). More specifically, Labrague et al. (2016) noted that faculty caring behavior had an impact on students' caring behavior. Fifer (2019) found positive correlations between student perceptions of instructor caring and age and race, and a negative correlation between student perceptions and employment. Finally, Henderson et al. (2020) noted that student intent to graduate was influenced by faculty caring.

The location of the triangle within the inner circle represents interaction between the affective characteristics and the structural components. The interaction of systems, subsystems, groups, and individuals within an organization results in the shared perception of the "feel" or "temperature" of the organization: the climate. Groups within an organization can be both formal and informal. Relationships are between the leader and groups of faculty and students, and the leader and individual faculty and individual students. There are faculty-to-faculty as well as faculty-to-student and student-to-student relationships.

Consistent with Benner's model of novice to expert (1982), the arrows descending from the circles representing the school of nursing illustrate the transition of student to graduate nurse to practitioner of relationship-based, patient-centered care. It is during the educational process in a caring climate and when caring is introduced early, reinforced throughout the curriculum, and modeled by leadership, faculty, and students, that students learn what caring is and begin practicing caring. As a new graduate, the nurse enters clinical practice as a novice or advanced beginner who demonstrates the caring behaviors learned and experienced during the educational process and continues to progress in the ability to provide relationship-based, patient-centered care.

Caring graduates

A caring climate in the school of nursing contributes to the development of caring graduates and their ability to provide relationship-based, patient-centered care, which is a priority for care recipients during the healthcare experience (Griffiths, Speed, Horne, & Keeley, 2012). Yet, the healthcare environment in which new graduates practice is not consistently supportive of the practice of caring (Deppoliti, 2008; Horsburgh & Ross, 2013), and new graduates struggle with acquisition of the professional role (Phillips, Kenny, Esterman, & Smith, 2014; Song & McCreary, 2020). Building on the knowledge, skill, and attitudes (KSAs) developed and molded during the educational experience, new graduates can continue to develop the ability to care as encouraged and role-modeled by preceptors, co-workers, and leaders in the practice arena.

Relationship-based patient-centered care

The concept of relationship-based, patient-centered care represents the ultimate vision of the Institute of Medicine (IOM) and is consistently described in the literature and by the healthcare industry (IOM, 2001; Picker Institute, 2013). The individual receiving care must be "known," indicating a relationship. In the relationship between nurse and patient there is communication, trust, respect, recognition of uniqueness, and sensitivity to values, culture, and preferences as well as involvement and participation by those in the relationship. Relationship-based, patient-centered care addresses all aspects of the patient's care including physical and emotional needs, education, and involvement of family and friends. From the nurse's standpoint, relationship-based, patient-centered care also includes knowing and being aware of the environment, the situation, and the

provider's own KSAs. Thus, the authors posit that the model provides a framework for creating an educational environment where graduates are better prepared to provide relationship-based, patient-centered care.

Synthesis

In summary, a Caring Model of Nursing Education is a comprehensive model that describes and explains caring within a school of nursing. It is a dynamic model of relationship, influence, and synergy at the micro (individual) and macro (organizational) levels that incorporates concepts from organizational climate, leadership, and caring theories. Transforming the school of nursing climate will provide an environment where the core value of caring serves as an antecedent in the process of preparing graduate nurses who provide relationship-based, patient-centered care.

The model can be used by nursing programs to create an environment where the core value of caring permeates every aspect of the organization. This climate is characterized by a relationship of trust among individuals, feelings of being valued, and having an ability to care among the faculty, and with students' perceptions that others care about them. The model also provides the framework for instrument development and several studies have explored various concepts of the model (Hayne et al., 2019; Phillips et al., 2018). Based on conversations with colleagues at national conferences as well as current doctoral students, the authors believe there is potential for additional studies that will provide further testing of the model.

Implications for nursing research

A Caring Model for Nursing Education describes the key concepts in a school of nursing that contribute to caring leaders, faculty, staff, students, the caring graduate, and the relationship between a caring graduate and patient. The use of this model to create a caring climate where everyone feels valued and respected could impact multiple outcomes. These outcomes include faculty job satisfaction; faculty and student retention; a civil, healthy work environment consistent with the NLN Board of Governors vision statement (2018); and nurturing of nursing students who develop the ability to provide relationship-based, patient-centered care. Studies, using readily available, valid, and reliable instruments, should be designed to document outcomes, test the components of the model individually and/or collectively, and demonstrate the interrelationship of the concepts contributing to a caring climate.

Conclusions

A Caring Model for Nursing Education presents a model where the core value of caring is designed, structured, supported, practiced, and evaluated in nursing education. The school of nursing climate is comprised of structural and affective characteristics. Structural characteristics are standards, leadership, and curriculum. Affective characteristics contributing to the school of nursing climate include the ability to care, the perception of caring by all individuals, and caring behaviors within the school of nursing. The dynamic interrelationship of these variables within a nursing education organization creates a caring climate. This model purports the contribution of nursing education to the perpetuation of caring as a core value and to the preparation of caring graduates to provide relationship-based, patient-centered care.

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