Development of an educational programme to support caring behaviours in nursing

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The candidate confirms that the work submitted is her own, except where work which has formed part of jointly-authored publications has been included. The contribution of the candidate and the other authors to this work has been explicitly indicated below. The candidate confirms that appropriate credit has been given within the thesis where reference has been made to the work of others.

Nafisa Iqbal Bardaie was responsible for study conception, study design, research ethics application, data acquisition, data analysis, data interpretation. The contribution of the other authors was assistance with study conception, study design, assisting with the selection of articles, data interpretation, and revision of the draft document.

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Abstract

Background

The foundation and core value of the nursing profession is caring. Good care giving ultimately results in patient satisfaction. The current evidence shows that patients and nurses are not satisfied with the provision of care by nurses.

Aim

The aim of this study was to explore the perceptions of patients, nurses, and student nurses regarding nurses' caring behaviours in Pakistan and develop an educational programme to enhance knowledge and understanding of the importance of caring in practice.

Methods

This study had three phases.

Phase one: a mixed-methods systematic review was conducted to synthesise the literature on the perceptions of caring behaviours among patients, nurses, and student nurses. Overall, 43 articles were reviewed and thematic analysis was used to synthesise the data.

Phase two: a qualitative exploratory-descriptive study was conducted. Overall, 45 participants were interviewed and framework analysis was used to analyse data.

Phase three: based on the findings in phase two, an educational programme pertaining to caring behaviours was developed by using the ADDIE framework. Nine stakeholders provided feedback on the educational programme.

Findings

The phase one informed the design and development of the topic guide for phase two. In phase two, eleven overarching concepts emerged from the participants' accounts. In phase three, the Caring Conceptual Framework developed from the qualitative findings was used to develop an educational programme on caring behaviours.
A comprehensive plan was developed and discussed with the stakeholders to identify its relevance and applicability.

Conclusion

This thesis achieved the aim of the study. The study findings contribute to the body of knowledge in the field of empirical research and practice. It enhances the knowledge and understating of the importance of caring behaviour in nursing practice. It highlights the importance of integrating caring concepts in nursing curricula and continuous in-service education for nurses. The educational programme is intended to help nurses to provide quality care to patients, potentially improving patient outcomes.

Table of Contents

List of Figures

List of Tables

Abbreviations

ADDIE	Analysis Design Development Implementation Evaluation
BPS	Basic Pay Scale
BSN	Bachelor of Science in Nursing
BHU	Basic Health Unit
CAT	Critical Appraisal Tool
CAT	Caring Assessment Tool
CASP	Critical Appraisal Skills Programme
CBA	Caring Behaviour Assessment
CBI	Caring Behaviour Inventory
CBI-E	Caring Behaviour Inventory- Elderly
CBS	Caring Behaviour Scale
CDI	Caring Dimension Inventory
CHW	Community Health Workers
CINAHL	Cumulative Index of Nursing in Allied Health Literature
DHQ	District Headquarters
FSc	Faculty of Science
HEC	Higher Education Commission
IRB-EC	Institutional Review Board and Ethical Committee
JBI	Joanna Briggs Institution checklist
JCIA	Joint Commission International Accreditation
LHV	Lady Health Visitors
MSN	Master of Science in Nursing
MMAT	Mixed Methods Assessment Tool
MMSR	Mixed-Methods Systematic Review

PIS	Participant Information Sheet
PhD	Philosophy in Nursing
Post RN-BSN	Post Registered Nurse Bachelor of Science in Nursing
PNC	Pakistan Nursing Council
RHC	Rural Health Centres
THQ	Tehsil Headquarters

Chapter 1

Introduction

1.1 Introduction

This chapter provides an introduction to the PhD study. The first section includes an overview of the culture in Pakistan by providing the context and setting for the study. The subsequent sections cover the background of caring behaviours and an overview of the nursing theories in general, particularly focusing on caring theories.

1.2 An overview of the Pakistani cultural context

Culture means the ways of life of a specific group with its 'values, beliefs, norms, patterns, and practices that are learned, shared, and transmitted intergenerationally' (Leininger, 1996, p.73). In Pakistan, the Islamic culture is the source of many aspects of culture, including religion, literature, art, architecture, dress, music, manners, and customs. Islam outlines each person's obligations and rights, even in terms of eating, drinking, and clothing. Therefore, it might be claimed that Pakistani culture is a true representation of Islamic culture (Rahman, 2010).

Considering the phenomena under investigation, that is, the caring behaviours of nurses, it is essential to describe the different contexts in which nurses are required to practice. The broader Pakistani cultural context and nursing culture will be described further in the next section.

1.2.1 Socio-demographic and ethnic-cultural context

Pakistan has a population of 207,774,520 which includes 106,449,322 males, 101,314,780 females, and 10,418 transgenders (*Pakistan Bureau of Statistics, 2018*). The breakdown of province wise urban and rural populations of Pakistan (*Health Statistics of Pakistan, 2019*) is illustrated in Figures 1 and 2.

Pakistan comprises of multi-cultural and multi-ethnic groups, which are categorised by religion, tribe, and language (Ali, 2013). Despite significant linguistic, cultural, and traditional diversity, the majority of the population adheres to Islam (Nauman, 2015). So, 95% of the population is Muslims. The remaining population is composed of Hindus, Christians, Sikh, and Parsis (Zaman et al., 2006). The largest ethnic group is from the province of Punjab with a population of 110,012,442 people (*Health Statistics of Pakistan, 2019*).

Figure 1: Province wise urban population of Pakistan

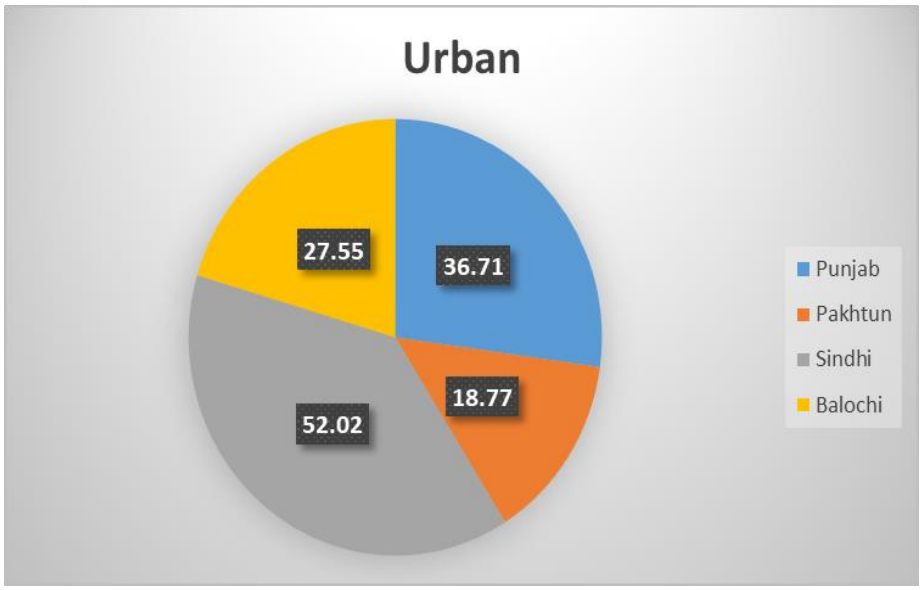
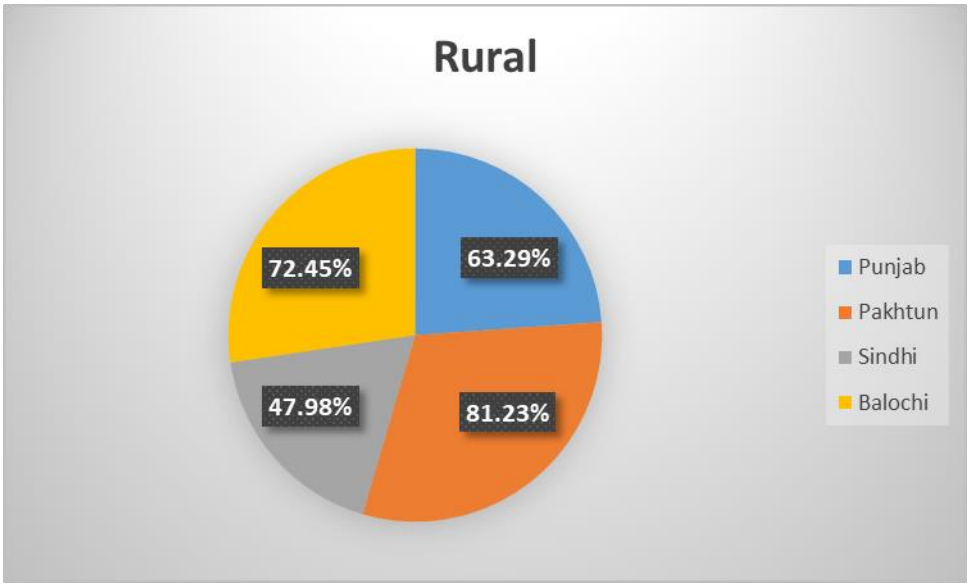


Figure 2: Province wise rural population of Pakistan



Because of cultural diversity, a variety of languages are spoken in Pakistan. Some of them are Balochi, Pushto, Brahui, Burushaski, Gujrati, Hindko, Saraiki, Sindhi, and Punjabi. However, Urdu is understood and spoken throughout Pakistan. Being the national language, it serves as the primary medium of communication throughout Pakistan and English is the official language (Rahman, 2010; Ali, 2013).

Nuclear and extended families are most common in Pakistan's rural and urban areas. Nuclear families include parents living with children, which may be found in urban areas, while both urban and rural sections of the country have extended families. Extended families have three or four generations living under the same roof (Naima, 2021).

A significant part of Pakistani cultural life is literature. The majority of poets use their poetry to express Islamic tradition and ethics. They spread the message of brotherhood and love. A significant aspect of contemporary cultural life is the conceptual similarity among poets and writers from various geographical areas. Pakistan has literature in different languages, such Urdu, Punjabi, Sindhi, Baluchi, Pushto, Persian and English (Mohanram and Rajan, 1996).

A significant culture manifestation is dress. The regional attire of Pakistan evolves in response to regional affluence, economic conditions, cultural practises, and local traditions. The shalwar-kameez is the most common clothing in all Provinces (Marsden, 2005; Haines, 2013; Ozyegin, 2016). In some areas, ladies who wear the shalwar-kameez typically wrap a long scarf or shawl known as a dupatta around their head or neck (Rait, 2005). Although it is composed of delicate cloth, the dupatta is also used as a form of modesty because it crosses the shoulders and hides the upper body's contours. The dupatta is a less restrictive option for Muslim women than the chador or burqa. In addition to the national costume, men frequently wear locally tailored suits and neckties, trousers, jeans, and shirts, which are accepted in workplaces, educational institutions, and social settings (Singh, 2004; Koerner and Russell, 2010).

The literacy rate of Pakistan is 58% (*Pakistan Economic Survey, 2017-18*). A person is called literate if s/he is able to read or write a simple letter for comprehending any language (Sundus, 2021).

1.2.1.1 Status of women in Pakistan

Pakistan has always been a patriarchal society, with men defining women's status. Men are in control of the financial earnings and family decision-making, while women are in charge of domestic and reproductive functions, such as childbirth and raising a child (Bhattacharya, 2014). Consequently, the low position of women has a significant influence on the profession's image.

Islam propagates the idea of equality between men and women. However, several cultural interpretations and discriminations are reflected in the existing laws and practices such as purdah (seclusion), which is a deeply ingrained concept in Muslim doctrine and practice, or freedom of movement and interaction with the opposite sex (Tabassum, 2016). This may be the reason that family members discourage their female members from pursuing the nursing profession because nurses work in the public realm and interact with males from outside their families. Women are subjected to socio-cultural limitations, and they are culturally compelled to stay at home and perform unpaid household duties (Kurji et al., 2016).

Women are not regarded as strong and capable enough to protect and guard themselves. As a result, men are socially given the responsibility to protect and safeguard the female members of the family (Isran and Isran, 2012). Women are assigned at home to perform household chores such as laundry, dish washing, cooking, sewing, rearing children, caring of senior family members, and many other similar tasks. In rural areas, the females are also involved in looking after the cows, sheep, chickens, and other food producing animals, as well as working in the fields (Amin et al., 2010). Due to their restricted mobility, women do not have the same amount of freedom as men do, and they have to take permission from their male family members before stepping out of the house. Many times, they are escorted by a male member of the family even when visiting the doctor (Adeel et al., 2017).

Pakistani families are more likely to get their daughters married at a young age, usually between the ages of 18 and 25. Marriages are usually arranged by the parents and the older family members. The practice of females making marriage related decisions was not accepted in the society. However, as the Pakistani society evolved, it became more acceptable for the parents to approve a marriage according to their children’s choices or wishes (Bhattacharya, 2014).

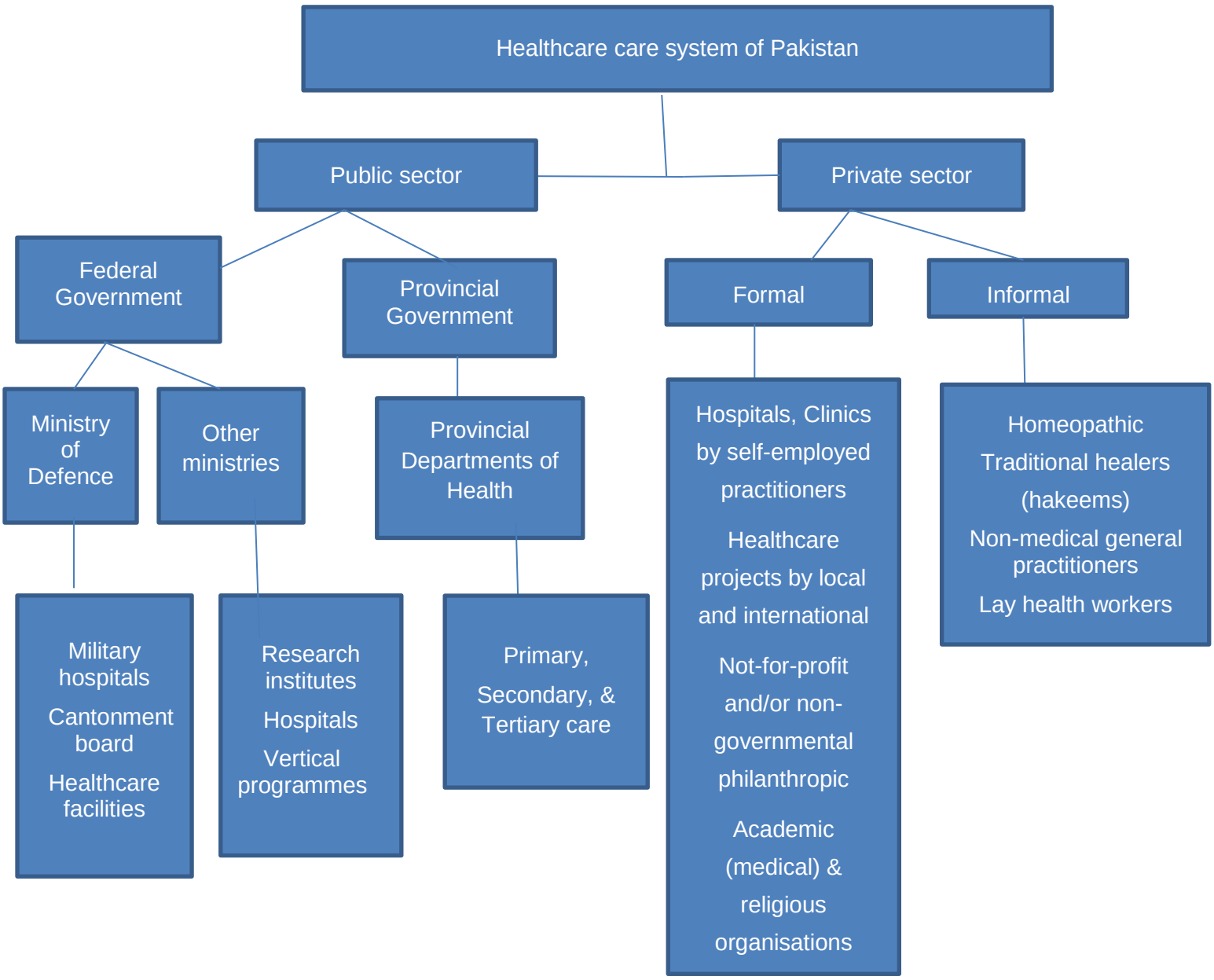
After marriage, a woman's prestige in the new home is determined by the number of children she produces, particularly sons. The birth of a son is the most celebrated, whereas the birth of a girl places a burden on the shoulders of the parents (particularly, for finding a good mate and the provision for the dowry at the time of her marriage) (Tabassum, 2016; Agha, 2018). Investing in the education of boys is favoured above investing in the education of daughters. Boys are given schooling with the expectation that it would result in an increase in the family's socioeconomic assets in the future (Qureshi, 2012).

1.2.2 Health care system in Pakistan

The health care system in Pakistan is divided into two sectors: public and private (Javed et al., 2018, p.172) (Figure 3). The public sector is divided into federal and provincial governments and they have their own autonomous health care systems. The primary, secondary, and tertiary healthcare comes under the provisional departments of health. According to WHO, EMRO, (*Pakistan Health Services delivery, 2019*) Report, the Basic Health Unit (BHU) and Rural Health Centres (RHC) are the primary health care services. At this level, preventive and promotive services are provided by the Community Health Workers (CHWs) through different national programmes. CHWs interact with the community through primary healthcare facilities and outreach programmes. Curative and rehabilitative services are provided at the secondary and tertiary levels at the Tehsil Headquarters (THQ) and the District Headquarters (DHQ). Tertiary care services are situated in large cities, which consist of teaching hospitals that provide inpatient services as well.

The public hospitals tend to be overcrowded and offer poor quality services. The inpatient expenditures are usually paid by the government, whereas outpatient costs are the responsibility of the patients, such as medicines and diagnostic procedures. Private hospitals, on the other hand, provide a high standard of care and charge fees for their services (Rahman et al., 2019). The private sector is divided into formal and informal systems. The formal system includes hospitals, clinics, and health care projects; whereas the informal system includes homeopathic and traditional healers (Javed et al., 2018). In both sectors, health services are offered by healthcare providers including nurses, Lady Health Visitors (LHVs), educators, managers, doctors, and paramedics (Nizar and Chagani, 2016).

Figure 3: Health care system in Pakistan



1.2.3 Nursing institutions and educational programmes in Pakistan

The Pakistan Nursing Council (PNC) and the Higher Education Commission (HEC) are the regulatory bodies that standardise nursing programmes. The PNC registers nurses, midwives, LHVs, Generic Bachelor of Science in Nursing (BSN), Post Registered Nurse Bachelor of Science in Nursing (Post RN-BSN), Post Registered Nurse Bachelor of Science in Midwifery (Post RN-BSM) programme, Master of Science in Nursing (MSN), and Philosophy in Nursing (PhD), and nurse practitioners (Figure 4).

In Pakistan, both public and private nursing institutions follow the PNC curriculum for the execution of nursing programmes. Both the institutions have a similar infrastructure,

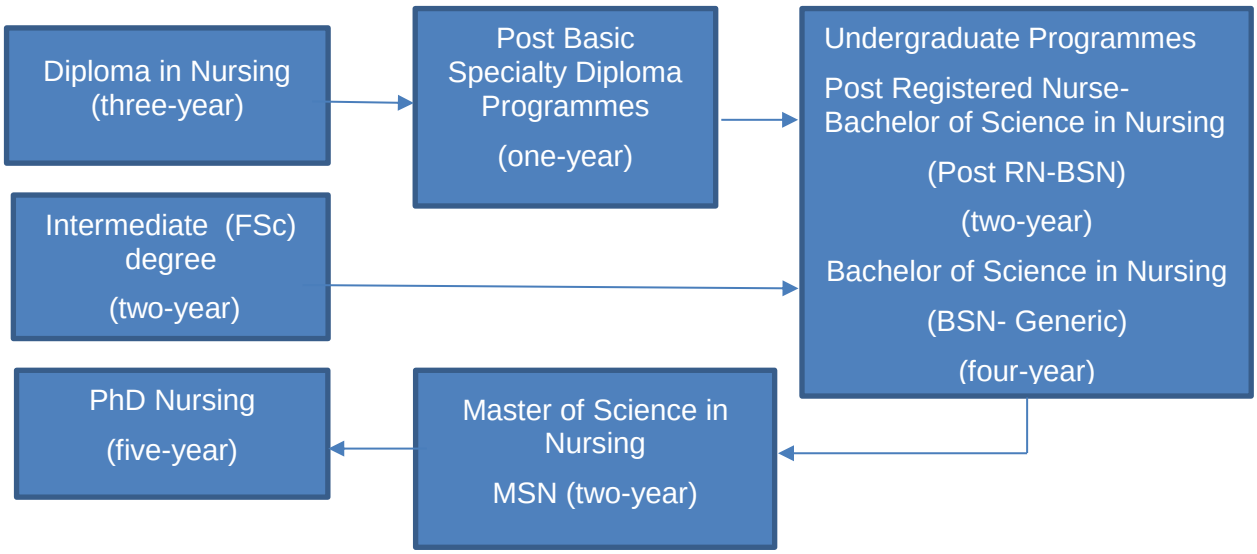
which includes, computer labs with internet facility, well equipped libraries, and skills labs.

The Lady Health Visitor is a public health nursing programme of 16 months. According to the two regulatory bodies, the Diploma in General Nursing was phased out in 2019. After completing the diploma level, nurses can apply for a post-basic specialisation programme of one-year duration, two-year Post RN-BSN and two-year Post RN-BSM programmes. The pre-requisite for admission into the Generic BSN programme is Intermediate Faculty of Science (FSc) premedical (Khowaja-Punjwani, 2020). The Generic BSN programme is delivered over four years. In the fifth year, student nurses have one year of clinical practice in healthcare settings, which is called the nursing internship programme. This internship is essential to obtain a license for clinical practice (*Curriculum of Nursing Education (BSN), 2011*). After completing the bachelor's degree, nurses can enrol in a post two-year Master of Science in Nursing (MSN) programme, which is offered by a few universities, whereas a PhD qualification in Nursing is offered by only three private nursing institutions.

For clinical exposure, student nurses go to different hospitals and community settings and are closely supervised by their clinical instructors or preceptors (Idrees and Shah, 2017). In the public sector, institutions follow an apprenticeship model where student nurses are supervised by senior nurses (Flott and Linden, 2016).

For the nursing curriculum, the regulatory body includes all the important content and current trends in BSN curriculum (Khan et al., 2015). However, caring behaviours have not been identified as a component in this curriculum. There are a number of required competencies in the undergraduate curriculum, such as communication, critical thinking, ethical, legal, and professional practice (*Curriculum of Nursing Education (BSN), 2006*).

Figure 4: Nursing educational programmes



1.2.4 Image of nursing profession in Pakistan

Image is defined as a mental value, belief, impression of a thing or person as perceived by the public for nurses and nursing (Venes, 2017). The public's perceptions of nursing have an impact on student nurse recruitment, funding for nursing education and research, relationship with health-care team, government agencies, and the profession's self-identity (Varaei et al., 2012). The most crucial point is that if others view the nursing profession negatively, this may have an impact on the nurse's behaviour.

The issue of nursing as a neglected profession with no value is faced globally by the educated and uneducated alike. According to the literature, several factors have contributed to the development of a negative image of nursing, including a lack of understanding of the role of nurses by the public; lack of acknowledgment from other health care teams; a low salary package, and a non-conducive working environment (Hamid et al., 2014).

Gulzar et al. (2016) identify several studies that have been conducted to investigate the status of nursing in Pakistan and found that the image of nursing is generally negative from its initiation. Over a period of time, due to advanced education in nursing, the impression of the public about nursing has changed (Yousafzai and Ul Huda, 2018).

1.2.5 Challenges of the healthcare system for nurses

1.2.5.1 Moral distress and ethical climate

The importance of creating an ethical climate and its impact on nurses experiencing moral distress in the workplace is an internationally recognised phenomenon. According to Jameton (1984) moral distress occurs when institutional constraints make it difficult to follow the appropriate course of conduct. Institutional betrayal could be considered as a source of moral distress. It is said to develop when internal or external restraints impede a healthcare provider's ability to fulfil their commitments to others (Rushton, 2018). Betrayal might undermine an individual's dignity and interfere with their potential to achieve self-actualisation (Parse, 2010).

The word institutional betrayal refers to gaslighting, which occurs when nurses who report workplace concerns (i.e., whistleblowers) are persuaded to believe that their complaints are unimportant or that workplace issues do not exist (Humphries and Woods, 2016; Saberi et al., 2019). This may cause cognitive dissonance in the individual who is gaslighted which may lead to significant emotional and psychological harm (Ahern, 2018).

There are various issues, including the inability to establish an environment in which the lack of resources (e.g., adequate staffing, equipment) (Bowles and Candela, 2005; Pendry, 2007; de Veer et al., 2013; Humphries and Woods, 2016), prioritising time is challenging for the nurses meaning that they cannot always provide patients with the level of care they desired (Usberg et al., 2021), as well as a lack of autonomy and safety to make ethical decisions about care of the patients (Cleary et al., 2018). Organisations may limit a nurse's ability to deliver ethical and high-quality treatment (Francine et al., 2013) and instilling in healthcare professional a sense of inability to speak out or complain about unethical practices or decisions, imposing external or internal limits on ethical practice, or failing to maintain organisational integrity. This limitation is thought to build self-betrayal in which a nurse betrays the patient (Rushton, 2018). Betrayal may also occur when an institution sets hurdles to ethical practice, such as laws that prioritise 'profit over humane care' (Rushton, 2018). Betrayal in the workplace could include an organisation or senior managers engaging in deceptive communication, ignoring the requirements of patients and providers, and failing to make decisions for the welfare of others (Rushton et al., 2010). Organisational betrayal is a concept used to characterise a work environment in which organisations respond to workplace difficulties by becoming hostile toward the victim, exhibiting a lack of concern about the issue (Brewer et al., 2020). Because of that, nurses may experience physical or emotional suffering (Pendry, 2007; Häggström et al., 2008), job dissatisfaction, and leave their job (Schluter et al., 2008). The literature shows a significant correlation between levels of moral distress and the ethical climate or environment of an organisation (Schluter et al., 2008; Silén et al., 2011; Francine et al., 2013). The degree and frequency of moral distress may be decreased if nurses have a supportive and more favourable ethical climate in the workplace (Silén et al., 2011; Bayat et al., 2019). The idea of an ethical climate is introduced by Victor and Cullen (1988). They describe it as the employees' perceptions about ethical events, practices, and procedures within an institution (Victor and Cullen, 1988).

An ethical climate in the institution is where nurses feel at ease expressing ethical issues, are aware of an ethical culture, participate in ethical deliberations (Murray, 2007), they are valued and respected, and allowed to voice their ethical concerns in their workplace (Schluter et al., 2008; Sherman and Pross, 2010).

1.2.5.2 Dignity in care

According to the World Health Organisation, enhancing and maintaining patient dignity is the most important domain as compared to providing prompt care (World Health Organization, 1994). Dignity is "inherent in an individual's sense of worth or value, which is closely related to respect, recognition, self-worth, and the capacity to make

decisions"(World Health Organization, 2015, p.1). So, dignity in care is an important concern in the health-care system (Valentine et al., 2008). It is a fundamental concept in nursing care. According to Nayeri et al. (2011) and Barclay (2016), dignity is also seen as a fundamental and important component of high-quality nursing care. Providing dignified care to the patients may promote emotional comfort and improve recovery (Williams and Irurita, 2004).

Nurses can foster human dignity through their interactions with their patients and other health-care professionals (Jo and Doorenbos, 2009; Tauber-Gilmore et al., 2018). Unfortunately, interactions between nurses and patients can result in behaviour that is regarded as disrespectful. This can happen in demanding circumstances, such as when there is a negative environment in a hospital or when patients and nurses are feeling emotionally dissatisfied (Grissinger, 2017). According to the Beth Israel Deaconess Medical Center (2015), insufficient respect for the patient as a person constitutes undignified treatment. Dignity is sometimes diminished because of a shortage of nurses and when nurses have heavy workloads (Baillie et al., 2008; Baillie and Gallagher, 2010). This can affect the nurses' behaviour and patients remember uncaring behaviours (Matiti, 2002; Jacelon, 2003; Calnan et al., 2005). Consequently, a nurse's poor or uncaring behaviour may threaten patient dignity (Gallagher and Seedhouse, 2002; Matiti, 2002; Walsh and Kowanko, 2002).

Therefore, dignity is a significant human need. Patients have a right to receive it and nurses are accountable for providing dignified care for patients (Gallagher and Seedhouse, 2002; Lin and Tsai, 2011; Lin et al., 2013; Cheraghi et al., 2015). The four factors important to provide dignified care are: physical environment (Gallagher and Seedhouse, 2002; Baillie et al., 2008; Gallagher et al., 2008); organisational culture (Gallagher and Seedhouse, 2002; Gallagher et al., 2008) during the implementation of care (Gallagher et al., 2008), and attitudes and behaviour of nurses and others (Gallagher and Seedhouse, 2002; Woolhead et al., 2006; Britain, 2007; Baillie, 2008; Baillie et al., 2008; Gallagher et al., 2008; Valentine et al., 2008). Gallagher et al. (2008) described these factors with examples in the physical environment of a care facility, including providing a single room, privacy, and access to amenities like bathrooms. In some instances, a lack of beds means that institutions adopt a mixed-sex bed arrangement in the ward which can pose a threat to patient dignity (Nordenfelt, 2003; Nordenfelt, 2004; Birrell et al., 2006). An organisation affirming a culture of care would encourage the staff members to acknowledge cultural diversity rather than solely fixating on therapeutic objectives. It is related to the 'hospital philosophy as well as the values and moral climate of the institution' (Lin et al., 2013, p.5). Care tasks such as, bathing, toileting, and dressing are needed while in the hospital and the attitudes and actions of the staff members while performing these tasks include how they interact

with patients, uphold confidentiality, respect, effective communication (Lin et al., 2013), patience, and tolerance (Gallagher et al., 2008). For example, Lin et al. (2011, p.797) conducted a qualitative descriptive study in Taiwan to examine how patients perceived dignity in care. They stated that having a 'sense of control and autonomy', 'being respected as a person', respecting patients' privacy, nurses' caring behaviour, 'confidentiality of disease information', and 'prompt response to patient needs' are all examples of what it means to treat patients with dignity.

1.2.5.3 Nursing challenges in Pakistan

Due to a lack of an appropriate service structure in the government hospitals, a nurse working in the Basic Pay Scale (BPS) must remain on the same grade for the entire duration of his/her employment (Hussain and Afzal, 2015). However, by working in the government hospitals, nurses have the advantage of long-term employment with a low risk of job termination. On the contrary, nurses in the private sector are paid better salaries and benefits, but job security is a major concern (Khowaja-Punjwani, 2020).

Gulzar et al. (2016) explain that nurses are overburdened, have limited resources in both clinical settings, as well as educational institutions, dominated by medical professionals and have limited opportunity for professional growth and involvement in health policy development. As a result, nurses perform their duty as a job rather than a career with a professional path. Nurses in Pakistan are usually involved in clerical tasks, such as meeting the patients' daily requirements like changing linen, supplying a hygiene kit and water, including resolving patients' complaints about housekeeping.

A study by Bahalkani et al. (2011) at a tertiary care hospital in Islamabad indicated that 86% of the nurses were unsatisfied with their jobs, while 26% were extremely dissatisfied. The main source of dissatisfaction was a non-conducive working environment, a low salary package, limited benefits, lack of respect, inadequate opportunity for training, and time constraints for caring for patients. In addition, a shortage of nurses is also one of the challenges that may affect patient care. This is because the Pakistani government has paid little attention to developing a nurse workforce strategy, resulting in low nurse-to-patient ratio. Nurses migrating to other countries has resulted in a weakened healthcare system too (Aluwihare-Samaranayake, 2017). Every year, over 15% nurses from developing countries, including Pakistan, migrate to developed countries (Hussain and Afzal, 2015). The main reasons for migration are the differences in salary, the political unrest in the country, personal protection, working conditions in the hospitals, lack of prospects for professional development, and a better quality of life (Khowaja-Punjwani, 2020). Hussain and Afzal (2015) reiterate that nurses in Pakistan migrate to foreign countries due to low status and image. There is a 93.41% shortage of nurses (*Pakistan Bureau*

of Statistics, 2018); and according to PNC, nursing institutes currently produce an average 9,728 nurses annually. This demonstrates the vast disparity between the supply and demand for nurses (Khowaja-Punjwani, 2020). Nonetheless, with a limited number of registered nurses, which are approximately 103,777 (*Health Statistics of Pakistan, 2019*), the health care system is unable to function efficiently (Parveen, 2016).

Nurses need to be empowered for decision making to become agents of change. By empowering nurses, the image of the nursing profession may be improved, which could help bring about job satisfaction and positive patient outcomes. A cross-sectional study was conducted in Pakistan to investigate the challenges faced by the nurses at public hospitals. Overall, 49.8% nurses said that they lacked authority and autonomy in clinical decision-making (Kousar et al., 2017). As a consequence of organisational challenges, lack of respect from patients, relatives, and doctors, increased workload, lack of teamwork between doctors and nurses, and a poor image of the nursing profession, the nurses in Pakistan are unable to practice independently (Somani et al., 2015; Hamid et al., 2016). In addition, nurses in Pakistan act as subordinates to the doctors, who hold a position of prominence in the health-care system (Jafree et al., 2015). Furthermore, many doctors do not consider nurses to be an integral part of their team and neither do they appreciate or respect them. It is observed in the private sector that nurses are restricted in performing nursing skills, such as nasogastric insertion, dressing, and catheterisation, which are strictly assigned to the doctors.

In recognition of the launch of the global ‘Nursing Now’ initiative, which aims to empower professional nursing and midwifery around the world (Stilwell, 2019), Pakistan’s president declared 2019 as the year of nursing to honour nurses’ efforts. This declaration supports the advancement of the nursing profession and the efforts to meet worldwide nursing standards. For long-term viability of the health-care systems, provision of quality nursing education is important (World Health Organization, 2015). Nurses need to be knowledgeable, committed, and competent to meet the healthcare challenges in nursing practice (World Health Organization, 2016).

The above section discussed the cultural context of Pakistan including socio-demographic information, healthcare system, educational institutions, image of nursing profession in Pakistan. The next section presents the background about caring behaviour.

1.3 Caring Behaviour

The foundation and core value of the nursing profession is caring. Worldwide, it is expected that nursing education will cultivate caring behaviours among nurses to fulfil the health needs of a patient (Li et al., 2016). Caring behaviour guides ethical care, which leads to quality health care (Pearcey, 2010). According to Greenhalgh et al. (1998, p.928), caring behaviour means, the “Act, conduct, and mannerism enacted by professional nurses that convey concern, safety, and attention to the patient.” Patient safety can be achieved when nurses and other healthcare team members take responsibility for their actions (Wei et al., 2020). Caring is an interactive process that builds a trusting and close relationship between the patient and the healthcare providers (Modic et al., 2014), which enables nurses to provide quality care to the patients (Fang et al., 2020).

The main aim of nurses demonstrating caring behaviours is to decrease the patient’s pain and suffering. Providing diligent care to the patients results in speedy healing and creates a sense of satisfaction for the patients (Watson, 2009; Kiliç and Öztunç, 2015; King et al., 2019; Ming et al., 2019).

Many researchers have indicated that caring behaviours lead to improvement in patient satisfaction (Omari et al., 2013; Papastavrou et al., 2014). However, current evidence shows that several patients and nurses are not satisfied with the provision of care by nurses (Aiken et al., 2012; You et al., 2013). Several studies have also indicated that this might be due to: the shortage of nurses and workload (Enns and Sawatzky, 2016); lack of education and inadequacy of skills (Roch et al., 2014 ; Sharma and Shrestha, 2015); reduced time and support from colleagues (Omari et al., 2013); inadequate support from management (Enns and Sawatzky, 2016); compassion fatigue (Burtson and Stichler, 2010); expectations of patients from nurses (Weyant et al., 2017); and cultural differences (Ian et al., 2016).

A study conducted by Ming et al. (2019) analysed patient complaints regarding nurses’ behaviours. Their findings indicated that nurses showed uncaring behaviours including incompetency in nursing skills, and unprofessional communication with the patients (Lotfi et al., 2019). Evidence indicated that nurses’ uncaring behaviours may be due to the non-alignment of expectations of patients and attitudes of nurses (Papastavrou et al., 2011; Wiechula et al., 2016). It is the responsibility of the nurses to deliver high-quality nursing care for quality outcomes for the patients (Omari et al., 2013), and one way to achieve this could be by fostering caring in nursing education (Labrague et al., 2016; Warshawski et al., 2018).

Caring can be divided into physical and expressive care. Physical care includes technical, therapeutic, and nursing interventions such as administering medication, providing hygiene care, maintaining a calm and comfortable environment, and delivering evidence-based care (Loke et al., 2015). Expressive care focuses on compassionate care, listening to the patients, fulfilling commitments, maintaining privacy, providing health education and advising the patients and their families, being sensitive to patients' needs and being trustworthy (Watson, 2002; McEnroe-Petitte, 2011; Labrague et al., 2015), and, showing respect, patience, gentleness (Loke et al., 2015), and empathy (Rego et al., 2010). Both physical and expressive dimensions of care are equally significant in determining health and well-being of patients (Loke et al., 2015). In other words, the attitude of nurses and the physical care provided by them may be considered a quality indicator within the healthcare organisations (Boykin et al., 2013; Bruce, 2018). Consequently, promoting patient's satisfaction (Labrague et al., 2017; Pajnkihar et al., 2017). Furthermore, Swanson (1999) emphasises the need to understand patients' experiences and build strong interpersonal and communication skills (Fukada, 2018). Effective communication such as listening and allowing the patients to express themselves can lead to quality patient care, patient's satisfaction, and reducing anxiety and fear among patients (Drahošová and Jarošová, 2016; Fortuno et al., 2017; Calong and Soriano, 2018).

The American Nurses Association (ANA) emphasises that nurses perform several roles such as providing care for patients, comforting and relaxing them, involving them in decision making, advocating, communicating, rehabilitating, educating, and advising them (Göçmen Baykara, 2014). The integration of expressive care in nursing education is important. Nursing institutions place a great emphasis on the cognitive and psychomotor aspects of caring. Although these domains are important for clinical practice, student nurses also need to develop their emotions and feelings towards the patients and strengthen their expressive care (Brown, 2011).

There is evidence in the literature that caring leads to positive quality outcomes for patients and that the nursing curriculum should encompass caring competencies, emotional and expressive aspect of care, alongside professional knowledge and skills (Mlinar, 2010). Furthermore, student nurses enrolled in the nursing profession have an optimistic caring vision. This should be reinforced consistently within nursing education (Dobrowolska and Palese, 2016; Labrague et al., 2017). The quality of the nursing teaching plays an essential part within the accomplishment of these competencies (Labrague et al., 2017). Nurse educators should nurture and empower the student nurses to internalise commitment and consistency in their caring behaviours (Brown, 2011). The student nurses can learn caring concepts in the classroom settings and

practice those concepts in the skills lab and clinical areas (Yilmaz and Çinar, 2017; Aupia et al., 2018; Erzincanlı and Yüksel, 2018; Allari et al., 2022).

Around the world, nursing education is expected to develop caring practices in the nurses to fulfil health needs of their patients (Li et al., 2016). It is considered a pivotal element of quality healthcare. Furthermore, within the fast-growing system of health care, nurses are challenged by task-oriented approaches, where they may not observe caring behaviours during their encounter with patients. To overcome these challenges, nurses should learn the required knowledge and skills, and build a caring attitude towards their patients.

A study conducted by Papastavrou et al. (2012) on patients and nurses' perceptions regarding caring behaviours showed that caring behaviours were frequently demonstrated by nurses in their daily practice and appreciated by the patients. This supports the idea that caring behaviours can be reinforced by the nurse educators, head nurses and by the nursing regulatory body in general. Some of the patient participants in Jardien-Baboo et al.'s (2016) study felt that emphasis should be placed on teaching the student nurses how to be compassionate and caring from the beginning and it should be reinforced through their curriculum and in on-going in-service training.

In hospitals, basic nursing skills, such as bed making and inserting intravenous catheters are frequently practised by nurses. These skills are important to learn; however, they also need to learn how to be empathetic and altruistic towards the patients (Fang et al., 2020). Studies have shown that education can help individuals to develop more caring attitude towards the patients (Wu et al., 2009; Lyneham and Levett-Jones, 2016). Two quasi-experimental pre-post studies were conducted to evaluate the effects of the educational intervention on the nurses' behaviour and patients' satisfaction (Sheikhmoonesi et al., 2013; Chan et al., 2015). The findings showed that a workshop based on caring behaviours had significantly improved nurses' behaviours (knowledge, attitude, skills) and patients' satisfaction. Additional educational training could be an important strategy for enhancing the nurses' knowledge, attitude, and practice regarding caring behaviours to improve the quality of nursing, that may increase the patient's satisfaction (Palese et al., 2011).

1.4 Critical analysis of nursing theories: identification of caring theories and its applicability to the Pakistani cultural context

Chinn and Kramer (1999) define a theory as “A creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of the phenomena” (p.51). Meleis (1977) defines nursing theory as the, “Conceptualisation of some aspect of reality that pertains to nursing” (p.16).

It is important to think critically about theories in a systematic manner, which could be the first step towards applying nursing theory to practice in different areas of education, research, administration, and clinical practice (Chinn and Kramer, 2015). In order to practice nursing at an advanced level, a nurse needs to have a greater comprehension of theory, as well as the capacity to apply theoretical knowledge effectively in providing health care for individuals (Cody and Kenney, 2006). Nolan (1996) explains that the utilisation of nursing theory in clinical settings is to improve and enhance patient care, improve the overall status of the nursing profession, promote communication amongst nurses, and provide guidance for research and education. It also gives nurses a feeling of self-identity, which aids them in making a distinct impact on the healthcare system (Draper, 1990).

1.4.1 Classification of nursing theories

Nursing theories are classified into four categories: metatheory or philosophy; grand or macro theory; middle range or mid-range theory, and situation-specific or practice, or micro theory (Alligood, 2017) (see Appendix A, a description of nursing theories). The Researcher reviewed 37 nursing theories as part of this thesis, and eight out of these theories, discuss the caring concept.

1.4.1.1 Meta theory or philosophy

Meta theory provides a world view of the nursing discipline through philosophy (Hickman, 2011). An example of Meta theory is Florence Nightingale’s ‘Environmental Theory’ introduced in 1860. She thought that healing requires a healthy environment, which includes, ventilation and warmth, noise free surroundings, healthy food, bed and bedding, light, cleanliness, personal hygiene, hope, and sound advice. She emphasised the importance of using critical thinking skills when caring for patients and taking the required and appropriate actions to aid in their recovery. She believed that observation skills should be used to influence patient care. This will be a guide to measure the progress or lack of response of the patients regarding the nursing intervention (Nightingale, 1969).

1.4.1.2 Grand or macro theory

Grand theory presents the detailed description of a conceptual model or framework in a narrative form. A conceptual model or framework is composed of concepts which describe their relationship with each other (Young et al., 2001). A grand theory is composed of abstract concepts that are not operationalised in nursing practice (Higgins and Moore, 2000; Hickman, 2011; Walker and Avant, 2011; Peterson, 2013).

Dorothea Orem's theory is an example of Grand or Macro theory. It was first published in 1971 with a focus on meeting the patient's biological, psychological, developmental, or social needs. This theory encourages the patients to take care of themselves (Orem, 1971). Orem (2001) claims that nurses 'compensate' for the patients as per their needs such as 'wholly compensatory' where the patient is unable to perform self-care activities; 'partially compensatory': when the patient is partially involved in self-care activities, and 'supportive educative system': when the nurse helps the patients to make decisions and learn new skills and knowledge.

1.4.1.3 Middle range or mid-range theory

Middle range theories are categorised into 'high-middle', 'middle', and 'low-middle' according to their abstraction level (Liehr and Smith, 1999). High-middle theories include the work of Benner. Patricia Benner introduced 'Novice to expert' in 1984. She explains the five stages of skills achievement in nursing practice such as 'novice', 'advanced beginner', 'competent', 'proficient' and 'expert.' This model can be utilised for career development, continuing education, student evaluation and supervising novice and student nurses (Benner, 2001; Benner et al., 2009). The knowledge acquisition, learning via hands-on clinical experience, and achieving clinical expertise are all key steps in providing direct patient care (Alligood, 2017).

An example of middle theory is, 'Uncertainty in Illness' (Mishel, 1984). Mishel explains that patients face stress due to hospitalisation and uncertainty occurs when they are unable to construct the meaning of their illness. After dealing with uncertainty, adaptability should be the desired outcome. Nurses may devise nursing interventions to address patient uncertainty (Mishel,1984;1999).

Low-middle theories that are close to practice, or situation-specific theories include, 'Theory of Chronic Sorrow' (Eakes et al., 1998). This theory discusses children with mental and physical disabilities. Parents may experience grief, sadness, sorrow, distress, frustration, and fear (Eakes et al., 1998).

1.4.1.4 Situation-specific practice or micro theory

Situation-specific, practice or micro theories are derived from mid-range theories and allow for practical experience and are empirically tested by different research approaches (Higgins and Moore, 2000; Peterson, 2013). In practice theory, goals are identified along with the interventions to achieve the prescribed goal, such as relief of cancer pain and end-of-life care (Walker and Avant, 2011). Nurses are expected to perform psychomotor skills, such as dressing changes, medication administration, venepuncture, and to provide education or counselling for the patients (Meleis, 2010; Im and Chang, 2012). In comparison to grand or middle range theories, practice theories are less abstract and easily applied in clinical practice and nursing research.

1.4.2 Caring theories

From a preliminary scoping search, several books were identified which discussed caring theories (Stassi et al., 2007; Alligood, 2010; George, 2011; Meleis, 2011). A brief overview of these caring theories is provided in Table 1.

Table 1: Description of caring theories

Title	Theorist	Year	Classification	Key features
Philosophy of Caring	Kari Martinsen	1970	Nursing Philosophy	Emphasises the consideration of a situational background of a patient and the family while undertaking the healthcare decisions.
The Philosophy and Science of Caring Theory of Transpersonal Caring	Jean Watson	1979	Nursing Philosophy	Presents 10 carative factors and a caritas process that provides guidelines for an interaction between a nurse and a patient.
Bureaucratic Caring	Marilyn Anne Ray	1984	Nursing Philosophy	This theory is focused on spiritual ethical caring and how organisational elements like legal, political, and economic factors influence nurses' caring behaviours. Nurses serve both the patients and the organisations. As an administrator, the nurse is in charge of making decisions that will benefit the organisations. Nurses, on the other hand, as primary care providers, have to deliver high-quality treatment to the

				patients.
Novice to Expert	Patricia Benner	1984	Nursing Philosophy	Describes the five levels of the skills acquisition and development: 1. Novice, 2. Advanced beginner.3. Competent, 4. Proficient, and 5. Expert
Theory of Caritative Caring	Katie Eriksson	1987	Nursing Philosophy	Describes the term caring which includes assistance, dignity, holiness, love, and respect of the human being.
Transcultural Nursing Theory	Madeline Leininger	1980	Grand Theory	Emphasises the caring should be based on the culture context of a patient. The theorist introduced the 'Sunrise Model'. This theory does not explain interpersonal or caring interaction with the patients, but it mentions the nurse's consideration of this component through collaboration between the patients and nurses, taking care of their eating pattern and preferences, protection from emotional distress, and preservation of energy while participating in self-care. It discusses holism, which means the combination of physiology, psychology, sociology, and spirituality.
Nursing as Caring	Anne Boykin and Savina Schoenhofer	1993	Grand Theory	'Persons are caring by virtue of their humanness', 'Persons live their caring moment to moment', 'Persons are whole or complete in the moment', 'Personhood is living life grounded in caring', 'Personhood is enhanced through participating in nurturing relationships with caring others', 'Describes nursing as a discipline and also as a profession'.
Caring Theory	Kristen Swanson	1991	Middle- Range Theory	Introduces five caring processes: 'maintaining belief', 'understanding (knowing)', 'conveying messages to the client through verbal and nonverbal communication (being with)', 'therapeutic

				action (doing for and enabling)', and the 'consequences of caring (intended client outcome)'.

The purpose of the majority of these theories is to provide a roadmap for the development of education rather than practicing the theories (Lathlean, 1994; Meleis, 2011). Furthermore, grand theories are abstract in nature with a greater breadth and complexity and do not provide specific nursing actions, but a basic framework and ideas about nursing. Most of the above-mentioned theories are classified as philosophy, which is abstract in nature and does not provide practical guidelines for patient care. But to excel in nursing care, a nurse should understand and have knowledge about the caring behaviours in a practical way (Andersson et al., 2015) . Application of these theories also requires a sound knowledge of the other disciplines such as anthropology, philosophy, and science because most of the concepts are taken from different fields (Alligood, 2017). The theories are often presented in a language not easy for practitioners to understand and may not provide explicit guidelines for contemporary nursing practice (Andersson et al., 2015). Consequently, there is a recognised theory-practice gap and a lack of implementation in practice (Lathlean, 1994; Meleis, 2011; Ahtisham and Jacoline, 2015). Hence, nurses must be able to comprehend the theories; otherwise, they will be less meaningful for them. They may regard nursing theory as irrelevant and impracticable in their practice. Furthermore, there is a difference in the socio-economic status, cultural contexts, health beliefs, and values among European/North American communities (where these theories are derived) that may not be generalised to the Pakistani cultural context.

1.5 Chapter summary

This section has presented an overview of the Pakistani cultural context and setting. Pakistan is a multi-cultural country with many ethnic groups divided into several languages, religions, and tribes. Pakistan's healthcare system is divided into public and private, and both have different financial, material, and human resources. Nursing schools are also classified as public or private and both follow the PNC and HEC approved curriculum.

The nursing profession faces many challenges, such as an inadequate educational system, low wages, and migration of nurses abroad leading to shortage of nurses. In addition, a lack of political and professional power may cause low status of nurses in Pakistan. In order to provide quality care for patients and satisfy their needs, more

nurses need to be trained and retained. In addition, the negative image of the role of the nurse in Pakistan is also an issue. This may be due to the fact that the role of nurses is not recognised by the doctors and public, which is a result of the status given to women in the society. To overcome this, nurses need to be empowered in decision making, as this may increase their job satisfaction.

Caring behaviour is the foundation of the ethical and moral values that help nurses to build therapeutic and trusting relationships with the patients. Nurses should be able to understand the concepts of the theories in order to apply them into practice. A lack of comprehension of nursing theories may lead to deficient use of nursing theory in the daily practice of nursing.

In daily routine practice, nurses in Pakistan might not always be able to see or understand the importance of caring. The awareness of nurses regarding caring behaviour should be increased to help them to act according to the patients' expectations (Fang et al., 2020). Therefore, it is important to understand the perceptions of the key stakeholders, such as patients, nurses, and student nurses about caring behaviours by nurses in the clinical settings, in Pakistan. This greater understanding can then be used to develop an educational programme to enhance the knowledge and understanding of the importance of caring in practice.

1.6 Thesis overview

There are six further chapters in this thesis. Chapter two presents the methodology which explains the three phases of the study. Chapter three presents the first phase of the project, a mixed-methods systematic review. A qualitative research method is explained in chapter four. Chapter five presents the qualitative research findings and discussion. A proposed plan for the educational programme is discussed in chapter six. Chapter seven concludes the findings from all the chapters.

Chapter 2

Methodology

2.1 Introduction

This chapter provides a detailed description of the research approach including an explanation of the research paradigm. An overview of the three phases of the study is also provided: phase one, embraces the mixed-methods systematic review; phase two includes the qualitative exploratory-descriptive study design, and phase three comprises the development of an educational programme.

2.2 Research approach

A research paradigm gives direction for knowledge generation and research design (Creswell and Creswell, 2017; Denzin and Lincoln, 2018). Research design is influenced by the nature of reality (ontology) and how information is obtained (epistemology) (Howell, 2013; Ormston et al., 2014).

Post- positivism and interpretivism are two philosophical perspectives. The positivist paradigm holds that reality exists independently and knowledge is gained by observation, such as through scientific experiments (Howell, 2013; Denzin and Lincoln, 2018). The interpretivist paradigm asserts that reality is not independent. In general, in the qualitative method, knowledge is gained through senses and the meaning of social phenomena is understood and interpreted (Marshall and Rossman, 2016). It is believed that truth is both multifaceted and dynamic in nature, which may be discovered through interaction with people in their socio-historical context. It is a naturalistic inquiry in which people and situations are studied in their natural environments (Sandelowski, 2000). It uses inductive reasoning to generate knowledge about the meaning of certain phenomena (Gray, 2009). Selection of a specific philosophical paradigm is recommended as a strategy to guide research methodology and procedures, as well as to draw conclusions regarding the study outcomes (Maxwell, 2012; Howell, 2013; Ormston et al., 2014).

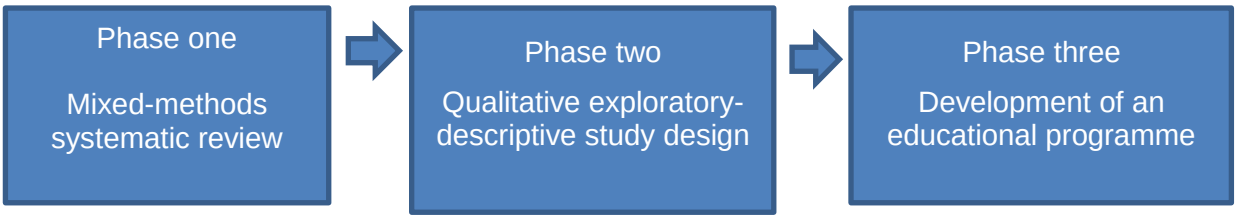
A qualitative approach with an interpretivist perspective was adopted for this research project, which is unlike a quantitative approach in which the researcher collects facts and figures and identifies the relationship between the variables (Lincoln, 1995; Ormston et al., 2014; Creswell and Creswell, 2017). A qualitative approach explores the viewpoint of the people and understands the meaning of their experiences, such as their social world views, attitudes, actions, and decisions (Jacobsen, 2012). In this perspective, reality is not objective or independent since perceptions are based on

participants' subjective interpretations. As a result, there may be multiple accounts of reality. The epistemological stance is that knowledge is formed through studying of the social world views and their interpretation contributing to knowledge development (Stebbins, 2001; Reid-Searl and Happell, 2012; Roberts and Messmer, 2012; Ormston et al., 2014; Denzin and Lincoln, 2018).

2.3 Overview of the study phases

This study had three phases. A diagrammatic representation of the study phases is provided in Figure 5.

Figure 5: Overview of study phases



2.3.1 Phase one: Mixed-methods systematic review

The objective of this phase was to retrieve, critically analyse and synthesise the existing literature related to the perceptions of caring behaviours by patients, nurses, and student nurses. A literature review is conducted to identify the current and most significant information about a phenomenon of interest. It also helps to identify the knowledge gaps in literature and enhances the areas of interest by determining what exists and what knowledge is needed for further research (Gray et al., 2016). The findings of the study are summarised, synthesised, and presented in an organised manner (Aveyard, 2014; Paré et al., 2015). There are several types of reviews to synthesise the literature. A brief description of each type of review is presented in Table 2.

Table 2: Types of review methods

Types	Description
Realist review	According to Jagosh et al. (2012): • This type of review aims to explain what, how, and why certain things work and under what conditions and situations. • It explains the association between a programme's context, mechanism, and desired results.

	• The final product of this review is to generate or refine a theory. • For example: a training programme related to employment was offered to a community with a high unemployment rate (context). But very few people enrolled in the programme (outcome). The reason was that people had difficulty reaching the venue because there were not enough public transportation options (mechanism) (Tricco et al., 2016).
Narrative literature review	According to Pae (2015): • There is no predefined protocol for searching the literature for this review. • It is a simple way of describing the study findings. • It may, therefore, be evidence-based, but these reviews are too selective and include little high-quality data, which may not be valuable as scientific evidence. • A traditional literature review is the evaluation and synthesis of the findings from journal articles, books, and other sources relevant to a particular problem or issue (Ramdhani et al., 2014).
Integrative review	According to Souza et al. (2010): • This type of review includes diverse and comprehensive research methods to fully understand the phenomenon of interest. • It includes information from both theoretical and empirical literature. • This review provides conceptual definition, analyses of theoretical and empirical evidence, and a study of methodological issues related to a particular topic. • The findings can be utilised as evidence-based practice in healthcare and contribute to the development of theory (Hopia et al., 2016).
Mixed-methods systematic review	• These techniques can be used to integrate the data from qualitative, quantitative, and mixed studies despite the differences between them. • These methodologies can have similar research aims and review questions (Heyvaert et al., 2017).
Qualitative systematic review	According (Butler et al., 2016; Samnani et al., 2017): • This review aims to analyse and synthesise the findings of the qualitative studies. • Its objective is to include the results into a larger category. • This may lead to further development of a new theory.
Meta-synthesis	• By combining the qualitative accounts of numerous studies on the areas of interest, this synthesis can expand current understanding by offering a broader framework for research practice (Chrastina, 2018).

	• The synthesis may lead to the generation of new theories, development of conceptual models, identification of research gaps, expansion of current knowledge in addition to providing evidence for the specific health care services (Mohammed et al., 2016)
Rapid review	• This review is a synthesis of the evidence using streamlined systematic review methods to answer a specific research question in a short time scale (Pandor et al., 2019). • It is time-bound and because of this, it may introduce publication bias and limit the quality appraisal of the studies (Samnani et al., 2017). • It is an innovative approach to knowledge synthesis that is used to inform about health-related policies, particularly when there is an urgent need for information (Lal and Adair, 2014).
Scoping review	• Regardless of the study quality, this review is intended to offer a general overview of the data relevant to a topic and provide knowledge for decision making (Tricco et al., 2016). • An assessment of methodological qualities of the evidence included is not performed unless it is required, based on the aim of the review. As the methodological quality appraisal is not conducted, the implications of policy making, or practice may be significantly limited in providing concrete guidelines in these areas (Munn et al., 2018).
Systematic review	• In this review, an explicit systematic approach is used to search, appraise, and synthesise research findings. This review provides more trustworthy findings from which conclusions and decisions can be made (Higgins and Green, 2011). • The pre specified list of questions and eligibility criteria are developed to search the literature and answer the review questions (Ramdhani et al., 2014; Tricco et al., 2016).
Umbrella review	According to Aromataris et al. (2015) and Papatheodorou (2019): • The compiling or aggregating of the evidence from the various systematic reviews. • It enables comparison and contrast of review findings pertinent to a review question. • It includes the highest level of evidence, such as meta-analyses.

Taking into account the types of reviews, and that there were qualitative and quantitative studies addressing the phenomena of interest, a mixed-methods

systematic review was undertaken. It is the most appropriate type of review to meet the objective of phase one for this study (described in Table 2).

There are many advantages to this type of review. Firstly, a review of the qualitative studies assists the interpretation of the quantitative findings. Secondly, a review of the quantitative studies supports the generalisation of the qualitative results. Thirdly, a review of both types of studies provides for a better understanding of an emerging phenomenon (Pluye and Hong, 2013). Integration of both types of research approaches, quantitative and qualitative, complement each other, and are useful to guide practice and policy (Noyes et al., 2019).

The rationale for using this design for the literature review was to provide an in-depth, comprehensive, and a richer account of the area of interest. This type of review enhances the credibility, validity, and integrity of the review findings (Hong et al., 2020). In a mixed-methods systematic review, there are several ways to analyse and synthesise the evidence:

- Configurative is ordering the results from primary research to produce or investigate new insights and interpret the phenomenon.
- Aggregative is collecting empirical data from primary studies and testing the hypothesis by adding the results to seek evidence for decision making (Sandelowski et al., 2012; Hong et al., 2020).

Other approaches for synthesising the data are: segregated; convergent integrated, and contingent designs (Sandelowski et al., 2006; Heyvaert et al., 2016; Lizarondo et al., 2017).

- Segregated: due to the traditional distinction between quantitative and qualitative techniques, the data should be analysed and synthesised separately in a segregated design. The separate findings should then be further synthesised. Both approaches address diverse research questions to similar areas of interest. Hence, without confirming and refuting, they can complement each other. As a result of this, the quantitative and qualitative evidence can only be organised coherently rather than being directly merged (Sandelowski et al., 2006).
- Convergent integrated: as both qualitative and quantitative studies are methodologically different, they address the same research objectives and questions in an integrated design. This approach enables the transformation of quantitative data into qualitative (qualitised data) for integration. Qualitising means transforming data from quantitative studies into categories, themes, typologies, or descriptions of the accounts in the form of narratives

(Sandelowski et al., 2006; Frantzen and Fetters, 2016; Heyvaert et al., 2017; Lizarondo et al., 2017).

- Contingent design: a cyclical approach with the focus of each subsequent synthesis being informed by the results of the previous one, until all research goals have been met.

Due to the broad review questions addressed by both qualitative and quantitative research methodologies, the integrated (convergent) approach was considered the most appropriate for this thesis. This allows the researcher to transform, synthesise, and combine the evidence of both research designs (Stern et al., 2020). This review followed the Joanna Briggs mixed–methods systematic review approach (Lizarondo et al., 2017).

2.3.2 Phase two: Qualitative exploratory-descriptive study design

The objective of this phase was to explore the perceptions of patients, nurses, and student nurses regarding nurses' caring behaviours in Pakistan. Phase one informed the design and development of the topic guide for phase two.

There are various qualitative research designs to explore the phenomena under study. The main ones include phenomenology; ethnography; grounded theory; participatory action research; historical research, and exploratory-descriptive qualitative study design.

The phenomenological design explores meaning and lived experiences (Brockopp and Hastings-Tolsma, 2003; Jarošová et al., 2009). Ethnography focuses on culture, and observing individuals, groups, or documents (Bradshaw et al., 2017). The grounded theory approach is derived from data relating to social phenomena and is especially useful when a topic area lacks theoretical underpinning (Jacobsen, 2012). The participatory action research design involves participation of both researchers and participants to examine a problem and generate data that directs development, implementation, and evaluation of the action plan for the betterment of the people (Kindon et al., 2007). Historical research is a narrative description of the events and analysis of data such as records, or artifacts (Speziale et al., 2011). The exploratory-descriptive qualitative study design is conducted to investigate and understand the manifestation of the phenomenon, which is little defined and explored (Polit and Beck, 2012). It allows contribution to the advancement of new knowledge in the phenomenon of interest (Reid-Searl and Happell, 2012).

Adopting one of the theoretical perspectives of ethnography, phenomenology, or grounded theory would not enable the achievement of the aim of this study. Using a qualitative approach, an exploratory-descriptive study design was used because the

focus of the research was to discover how participants perceive and experience caring behaviours of nurses in the hospital settings. Furthermore, little is known about the phenomenon of caring behaviours of nurses in Pakistan and this design was thought to be the most likely to elicit understanding of the phenomena under investigation. The knowledge gained through this design helps to build, implement, and evaluate the educational programme for nurses (Gray et al., 2016). This may improve patient's health outcomes.

2.3.2.1 Sampling strategy

Participants are often selected as having experience of the phenomenon of interest (Streubert and Carpenter, 2011) and can provide rich information of their practices (Liamputtong, 2013). There are several sampling methods in qualitative research to select research participants. These include convenience, quota, snowball, theoretical, and purposive sampling (Brockopp and Hastings-Tolsma, 2003; Ritchie and Lewis, 2014).

Convenience sampling involves selecting participants who are conveniently available (Parahoo, 2014). The researcher informs participants about the study, and it is up to the participant whether to take part in the study (Stratton, 2021).

There are two types of quota sampling. Proportionate sampling involves selecting the participants based on a ratio scale. The sampling is not stopped until the proportionate number is reached. Non-proportional sampling involves selecting the participants, such as those based on age, gender, religion, and education (Etikan and Bala, 2017). It enables the researcher to ensure that a specific trait of population sample will be accurately represented (Acharya et al., 2013).

Snowball sampling is an approach using a network of groups. This approach is helpful when the researcher is unfamiliar with the group being studied. Individuals who the researcher contacts recommend others to participate in the study (Etikan and Bala, 2017). The snowball approach is also called chain referral sampling because it is often used to find rare populations. This process continues until an adequate number of eligible participants have been identified (Johnson, 2014).

Theoretical sampling involves collecting and analysing data to recognise emergent concepts to decide what, where, how, and from what source to find more data to construct theory (Butler et al., 2016; Conlon et al., 2020).

Purposive or judgmental sampling is used when choosing the units to be researched, such as individuals, events, cases, or a piece of data, depending on the researcher's judgment (Sharma, 2017). A certain group of individuals are essential to be considered

for the study since they may have a unique and significant perspective on the concepts and problems under deliberation (Campbell et al., 2020).

The aim of sampling should be to obtain the most representative sample of a population and explore the variability and richness of the participants' perceptions, and understanding of the phenomena which can be best achieved through purposive sampling (Neergaard et al., 2009; Parahoo, 2014; Bradshaw et al., 2017). In the qualitative exploratory-descriptive study design, phase two of this thesis, the participants were recruited using this approach. The participants were selected based on their level of expertise or experience with a phenomenon of interest, their availability, willingness to take part in the study, and their capacity to present, articulate, and express their understanding and ideas (Palinkas et al., 2015).

The sampling frame for all three groups of the study comprised of males and females, those from different age groups, educational backgrounds, different medical and surgical departments of different institutions. For the patient sample, the number of hospitalisations and for nurses, clinical experiences in the medical and surgical departments were also included.

2.3.2.2 Data collection approach

In qualitative research, there are several ways to collect data: observation; interview; focus groups; and document review. Table 3 provides an overview of the data collection approaches, including the advantages and disadvantages.

Table 3: Advantages and disadvantages of qualitative data collection approaches

Data collection approaches	Advantages	Disadvantages
Observation This approach is to understand the roles, behaviours, and actions of the participants to provide a rich description of the phenomena (Walshe et al., 2012). According to Gray et al. (2016): • The researchers go with some pre-set ideas and keep the record of observation through video recording and by writing notes.	According to Creswell and Clark (2017) the researcher is able to observe participants in areas which may be difficult to discuss in interviews.	According to Tracy (2013): • During observation participants may alter their behaviour. • Observations may be restricted for privacy concerns.

• There are four methods: complete participation; participant as observer; observer as participant, and complete observation. **Complete participation:** People in the setting may be unaware that the researcher(s) is the participant. Researchers observe individuals and interact with them without obtaining consent from them (Streubert and Carpenter, 2011; Serry and Liamputtong, 2013). **Participants as observer role:** Participants are typically aware of the researcher's dual roles from the start of the observation (Tracy, 2019). **Observers as participants**: If the researchers are fully immersed in the circumstance, they may be unable to take down important information. They follow an emerging event within the research setting (Streubert and Carpenter, 2011). **Complete observation:** Researchers assume the passive role without interacting with the individuals within the research setting (Speziale et al., 2011)		
Interview This is a face-to-face strategy where researchers use unstructured or semi structured open-ended questions to elicit the opinion, view, or perspectives from the participants (Brockopp and	In interviews, participants can freely discuss confidential issues instead of being directly observed (Creswell and Clark, 2017).	According to Creswell and Clark (2017) • Researcher(s) role may be perceived as intrusive. • The presence of researchers may influence (bias) the responses of participants.

Hastings-Tolsma, 2003; Colorafi and Evans, 2016). According to Marshall and Rossman (2014): • The unstructured interview is preferred for an ethnographical or phenomenology study design. • Semi-structured or organised interviews are guided by open-ended questions. This can be either guided by few primary questions with prompts or designed with a variety of predetermined questions to focus the interviews on aspects of the topic under investigation.		• Participants may not be as articulate and insightful.
Focus Groups • A group of individuals facilitated by a moderator discuss a particular topic and share their experiences and beliefs (Nyumba et al., 2018). • The participants of the focus group are chosen because they share a certain trait (Krueger, 2015).	The researchers are able to understand the issues collectively while interacting with the participants (Morgan, 1996; Gray, 2009; Krueger, 2015).	• Participants may hesitate to discuss a sensitive topic in a group and 'group think' may occur (Polit and Beck, 2012). • Difficult to recruit a group of people (Marshall and Rossman, 2014). • If there are few participants attending a focus group, the discussion may be insufficient (Gray et al., 2016). • Focus groups are seen as being deficient in both depth and richness compared to individual interviews (Morgan, 1996).
Document analysis Reviewing, analysing, and interpreting the data from documents either public (meeting minutes or official documents) or private (personal diaries and letters) to gain an understanding	According to (Creswell and Clark, 2017): • It may save researcher's expense and time of transcribing data • Data can be retrieved at a convenient time by	According to (Creswell and Clark, 2017): • Confidential information may not be publicly available, and accessibility is difficult • The researchers may get incomplete, unauthentic, and inaccurate

of the knowledge (Corbin and Strauss, 2008).	the researchers	information

For this study, data were collected through in-depth semi-structured interviews using a topic guide (described in Table 3) (see Appendix F). This method allows the researcher to explore in-depth data which facilitates to understand the new concepts (Doody and Noonan, 2013). It also enables participants to express their point of view freely (Sandelowski, 2000). Using of topic guide may provide focused guidance about the topic to be addressed in interviews (Sullivan-Bolyai et al., 2005).

2.3.2.3 Data analysis

Deductive, inductive, or combined approaches can be used to analyse the data. In the deductive approach, data can be analysed through themes from previous theories or study questions. In an inductive approach, the aim is to identify emergent categories based on the concepts and theories from the data rather than using the deductive approach and a priori categories (Gale et al., 2013; Ritchie and Lewis, 2014). For this study, an inductive process was used. Inductive reasoning is used to develop abstract concepts or themes from the images, documents, or the participants' verbatim responses. Patterns or ideas that appear repeatedly in the data are referred to as themes. This inductive method makes data organisation, reduction, and grouping easy (Creswell, 2013; Maxwell, 2013).

There are a number of approaches to analyse qualitative data, including content, thematic, and framework analysis. Content analysis is the descriptive approach in quantifying the frequency of the codes and categorising data to determine patterns and trends (Gale et al., 2013). Thematic analysis involves identifying, analysing, and reporting analytical themes or nuance within the data (Braun and Clarke, 2012).

Framework analysis can be utilised to extract relevant themes from the data, while also ensuring that the accounts of the participants are appropriately represented (Smith and Firth, 2011). In the qualitative exploratory-descriptive study design, phase two of this thesis, framework analysis, developed by Ritchie and Lewis (2014) was selected for data analysis. It places a higher focus on moving back and forth across the data until a coherent account emerges. Furthermore, framework analysis has greater emphasis on explanatory accounts with constantly refined themes, which can lead to the creation of a conceptual framework. This enables the researcher to explore data in depth while simultaneously maintaining an effective and transparent audit trail, which enhances the rigour of the analytical processes and the credibility of the findings.

2.3.3 Phase three: development of an educational programme

Findings of phase two informed the development of an educational programme for nurses that enhances knowledge and understanding of the importance of caring in practice. An instructional design which can be used to help develop an educational programme, refers to the planning and implementation of educational training in a systematic, consistent, and reliable manner (Schott and Seel, 2015). This is the process of selecting effective teaching and learning strategies, identifying and choosing relevant educational media and technologies, and evaluating the performance of the participants (Branch and Kopcha, 2014). There are different instructional design models such as Rapid Prototyping (Piskurich, 2000); ASSURE model (Heinich et al., 1993); Dick and Clare model (Dick et al., 2011); Kemp model (Kemp, 1977); Gagne's model (Gagne, 1974) and the ADDIE model (Branson, 1978) (see Table 4).

Table 4: Description of instructional designs

Instructional designs & steps	Description
Rapid Prototyping (Piskurich, 2000) • Gathering information • Design (prototype) • Review • Develop • Implement • Evaluate	According to Kang et al. (2016): • It is a process of developing and evaluating a preliminary version of any product. • The mutual opinion and learning are shared between users and programme developers. • However, it is used for software engineering and particularly for computer-based teaching instruction (Tripp and Bichelmeyer, 1990).
ASSURE model (Heinich et al., 1993) • Analyse • State objectives • Select materials • Utilise materials • Require learner responses • Evaluate	• The step-by-step procedures for developing lessons that successfully incorporate the use of media and technology to enhance students' learning (BAVLI and Erişen, 2015; Ibrahim, 2015; Bajracharya, 2019). • However, it is more focused on a single lesson or topic and may be best suited for remote learning (Baran, 2010; Bajracharya, 2019).
Dick and Clare model (Dick et al., 2011) • Identifying instructional goal • Instructional analysis • Analysing learners and context • Writing performance objectives	This model provides an: • interrelated, structured and organised tool in developing the educational instructional design and contribute towards the achievement of educational goals (D'Angelo et al., 2018).

• Developing assessment instrument • Developing instructional strategy • Developing and selecting instructional material • Designing and conducting formative evaluation • Designing and conducting summative evaluation	• extensive procedure of planning and developing an educational programme (Khalil and Elkhider, 2016).
Kemp model (Kemp, 1977) • Instructional programme • Identification, and goal specification of an instructional course • Examination of learners' characteristics based on the instructional decisions • Subject content identification with task analysis related to goals and purposes • Instructional objectives specification • Instructional unit arranged in logical sequential order of learning • Instructional strategies designed to meet the mastery of lesson objectives • Plan and develop instruction • Evaluate instruments for measuring course objectives • Resource selection for instruction and learning activities	According to Ibrahim (2015): • This approach stresses the interdependencies between each stage of the educational process. • It emphasises the value of evaluation, and takes additional environmental elements into account in educational settings, such as resources in terms of budget, equipment, time, and human resources
Gagne's model (Gagne, 1974) • Gaining attention • Informing the learners of the objectives • Stimulating the recall of prerequisite learning • Presenting the stimulus material • Providing learning guidance • Eliciting the performance • Providing feedback about performance correctness • Assessing performance • Enhancing retention and transfer	According to Khadjooi et al. (2011): • This instructional design focuses on the learning outcomes and how to arrange instructional events to attain those outcomes. • It provides a structured format for a lesson plan.
ADDIE model (Branson, 1978) • Analysis • Design • Development • Implementation	According to Khalil and Elkhider (2016): • This model provides a systematic approach for developing educational instruction. The outcome of each

• Evaluation	phase of this model apprises the following stage. • This model is simpler and easier to use, especially for novice instructional designers. • It uses a behavioural approach in designing educational instruction. • ADDIE is an umbrella model from which all the models, their frameworks and their key elements have been derived (Mutlu, 2016).

Although the literature suggests a number of instructional designs for developing educational programmes, for this study, the ADDIE model devised by Branson (1978) was used as a framework in designing and developing the educational programme. Each phase of this model is interlinked with the other and guides which tasks need to be performed under each phase. It was developed for the American armed forces in the mid-1970s. It was also used as an instructional design to teach interpretation of chest radiographs to the residents of internal medicine, to help them diagnose and manage respiratory diseases of patients (Cheung, 2016). Hsu et al. (2014) used this model to develop an online continuing educational course on caring behaviours for Taiwanese nurses.

Based on the ADDIE model, the educational programme on caring behaviours was developed for nurses and evaluated by the stakeholders. Collaboration with the stakeholders and utilising their input in the form of suggestions, comments, and critique can be a significant contribution for the course development (Matkovic et al., 2014). The goal of developing the group of stakeholders was to present the findings of the study, share the action plan of a proposed educational programme to get their views about the practicality of the programme, and to propose recommendations for improvement (Krystallidou et al., 2018).

2.4 Chapter summary

This chapter has discussed the methods for the three phases of the thesis. It discussed the rationale for selecting a mixed-methods systematic review and qualitative exploratory-descriptive study design. A mixed-methods systematic review was conducted to explore the perceptions of caring behaviours among patients, nurses, and student nurses to provide a comprehensive view of this concept. Phase two was conducted to understand what patients, nurses, and student nurses perceive about the caring behaviours in Pakistani cultural context. The findings from phase two informed

the development of an educational programme for the nurses to enable them to provide quality care for patients and improve their health outcomes.

Chapter 3

Phase one: Mixed-methods systematic review

3.1 Introduction

This chapter provides the literature review pertaining to perceptions of caring behaviours among patients, nurses, and student nurses. It includes a brief description of the mixed-methods approach used in this review, along with the findings. The implications of the review on the education and clinical fields are also presented.

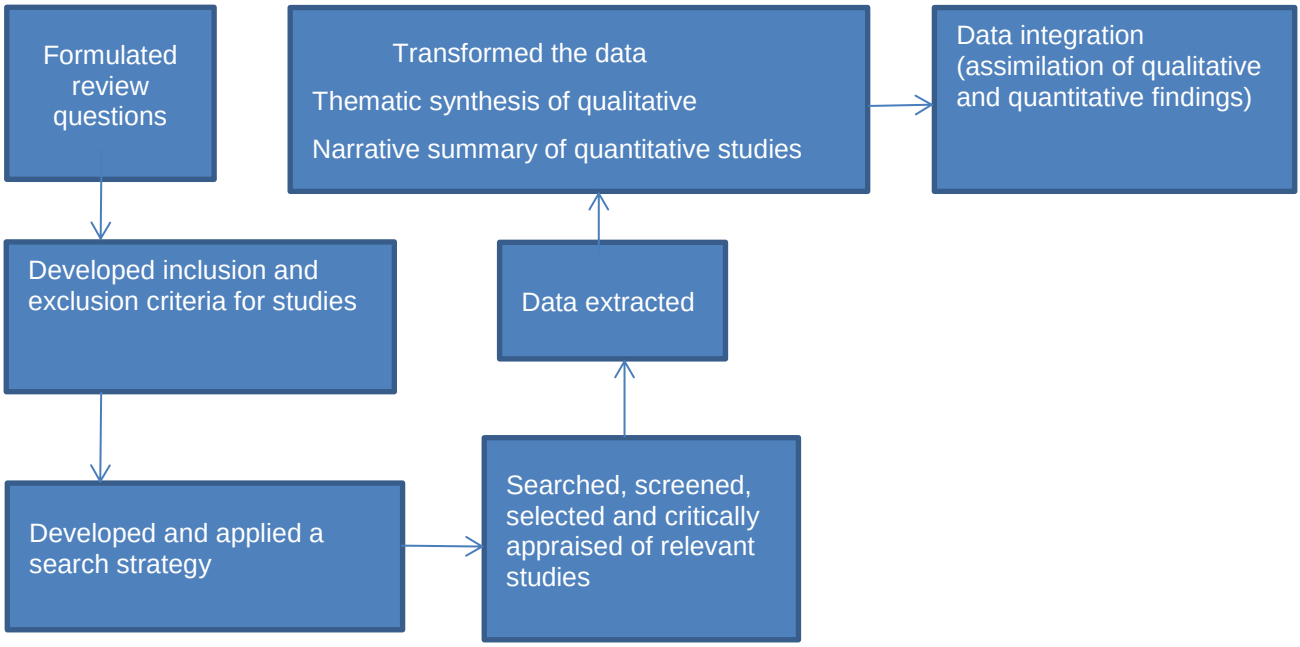
3.2 Methods

3.2.1 Problem identification

In the past ten years, there has been increased attention to caring behaviours among patients, nurses, and student nurses. It is well recognised that most of the studies have explored caring and uncaring behaviours, and the relationships of caring behaviours to demographics. However, little is known about caring behaviours in terms of spiritual and cultural care, the autonomy of the patients in decision making and care, counselling, and advocacy for the patients. From a preliminary review of the literature, very few of the studies were conducted in a Pakistani cultural context.

Three previous reviews related to the study topic were found: one quantitative systematic review, one mixed-methods systematic review, and one narrative review. The quantitative systematic review compared the perceptions of caring behaviours among nurses and patients (Papastavrou et al., 2011). The mixed-methods systematic review identified the qualities of a good nurse (Van der Elst et al., 2012). The narrative review identified the most important caring behaviours of the nurses (Potter and Fogel, 2013), However, all were conducted over nine years ago and other literature has since been published. Therefore, it was important to synthesise the most recent evidence related to the perceptions of patients, nurses, and student nurses of caring behaviours exhibited by nurses, and as there were qualitative and quantitative studies addressing this area, a mixed-methods systematic review was undertaken (Lizarondo et al., 2017) (see Figure 6).

Figure 6: Mixed-methods systematic review process



3.2.2 Literature search

The first search was undertaken in September 2019. In the initial search (n=33) articles were eligible for the systematic review. Two updated searches were conducted in June 2021 (n=9) and in September 2022 (n=1) and the 10 articles were also included in the review.

3.2.2.1 Inclusion and exclusion criteria

The researcher created eligibility criteria before beginning the process of searching and retrieving the articles to address the research questions. The eligibility of the studies was determined by defined inclusion and exclusion criteria. Criteria were developed based on the review questions and review design. Studies published between January 2009–September 2022 and in English language were included. This time frame was selected to identify the most current articles for the review (Hunter et al., 2019). The studies not meeting the inclusion criteria and those that did not explore the phenomena of interest, were excluded (Meline, 2006; Levac et al., 2010). The inclusion and exclusion criteria for this review are provided in Tables 5 and 6.

Table 5: Inclusion criteria

Research approaches	Participants	Phenomenon of interest	Outcome	Context
Quantitative	Patients, nurses, and student nurses	Caring behaviours	Perceptions	Hospital settings (medical, surgical, cardiology, rehabilitation)
Qualitative				Educational settings
Mixed-methods				

Table 6: Exclusion criteria

Studies were excluded if they	Rationale for exclusion
Focused on the perceptions of caring behaviours by the participants solely working in Emergency, Palliative Care, Community, and Primary Care.	These areas require special care, such as technical and long-term care.
Focused solely on the concepts of dignity, compassion, empathy, respect, and quality care.	These are the concepts which are defined under the umbrella of caring behaviours. To get a general idea about caring behaviours these concepts were excluded.
Had only family members, children, or other health care staff.	Nurses are not directly involved in patient care; children may not perceive caring behaviours of nurses, and family members do not directly experience the nurses' behaviours.
Reviews and dissertations.	Reviews are the secondary source. Dissertations are often not published and have not been peer-reviewed.
Were not in the English language.	Other languages required rigorous process of translating the data.

3.2.2.2 Search strategy

A review protocol with well-defined review questions and inclusion criteria formed the basis for the search strategy. For example, the type of data being sought, qualitative or quantitative, the types of studies (descriptive, cohort, or ethnographic), and the limitations, such as publication date and language, must all be considered (Aromataris and Riitano, 2014).

The following six relevant databases were searched for the study: MEDLINE, Web of Science, Scopus, Cumulative Index of Nursing in Allied Health Literature (CINAHL), psychology (PsycINFO) and Embase. The limits such as studies in English language and publication time period were used for all the databases. In addition, articles were

manually searched to identify any additional studies using citation and the reference lists of all the included studies.

Key search terms

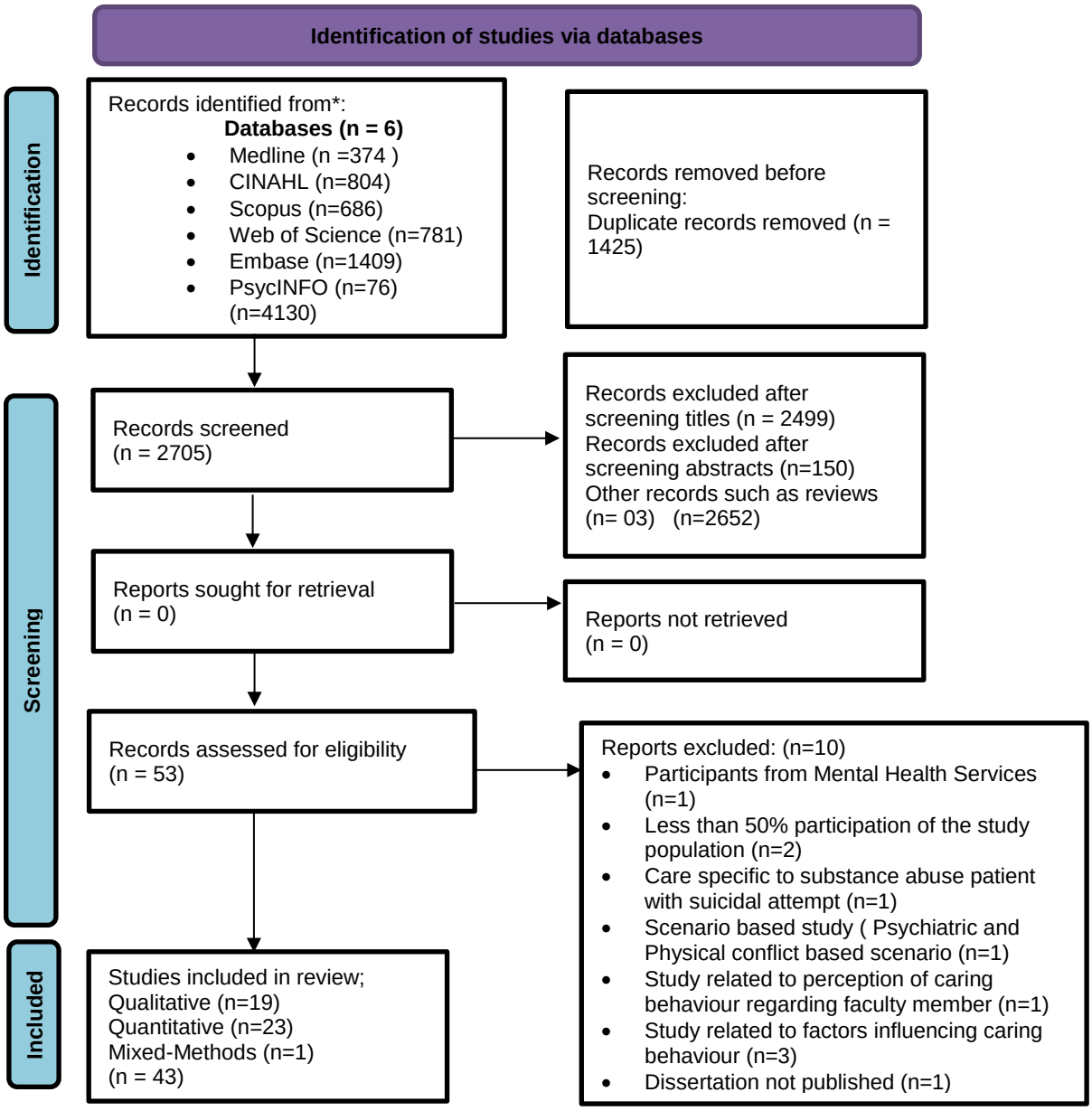
The review questions guide the key terms or concepts (Aromataris and Riitano, 2014). When formulating a search strategy, a search tool is required to organise the list of terms derived from the main concepts in the literature review questions. There are different types of search tools, such as 'PICO' (Population, Intervention, Comparison and Outcomes), which are usually used for quantitative studies. These tools may not appropriately retrieve qualitative research studies (Methley et al., 2014). To address this issue, Cooke et al. (2012) developed the 'SPIDER' tool (sample, phenomenon of interest, design, evaluation, research type) to identify relevant studies.

For this study, the 'SPIDER' search tool was used to identify the literature (See Appendix B). The key terms were identified from the titles and abstracts of the relevant studies, and by using MESH terms in the data bases. Key search terms were 'caring', 'caring behaviours', 'compassionate care', 'empathy', 'perceptions', 'experience', 'hospitalised patients', 'nurses', and 'student nurses.' Individual key terms and their combinations with the use of the Boolean operators, such as 'AND', and 'OR' were used. Proximity searching was applied by using, 'adj' and 'NEAR', between the words or phrases to get the closest terms. 'Truncation' (*) was used at the end of the key terms to retrieve the search associated to it. 'Wild cards' (?), were used to search for the terms with the different spellings. A similar search strategy was applied to each database. An example of the search strategy used in one database is presented in Appendix C.

3.2.2.3 Study selection

This literature search retrieved 4130 articles. Duplicates were removed before screening. Titles and abstracts were screened by three reviewers (the researcher and the PhD supervisors) and discrepancies resolved to reach a consensus among all the reviewers. Titles and abstracts that did not meet the inclusion criteria were excluded. Full text articles were screened by the researcher. A total of 43 studies were selected for appraisal of the methodological quality. The results of the search are presented in a PRISMA flow chart (Page et al., 2021) (Figure 7).

Figure 7: Prisma flow chart



3.2.2.4 Assessment of methodological quality

Critical appraisal of the literature is important in order to get good quality evidence for the review (Burls, 2014). There are several types of critical appraisal tools (CAT), for example, the Critical Appraisal Skills Program (CASP); Joanna Briggs Institution checklist (JBI), McMaster Critical Review Form and many others. For this review, the Mixed Methods Appraisal Tool (MMAT) was used to critically appraise the selected studies (Hong et al., 2018) (see Appendix D). This tool enables the appraisal of empirical studies, such as qualitative, quantitative, and mixed-methods studies. A limited number of criteria of the tool enables the appraisal of the quality of the evidence of the included studies quickly and efficiently (Hong et al., 2018). The narrative presentation of each criterion is encouraged because only using a number does not

provide a complete assessment about the methodological aspects of the studies (Crowe and Sheppard, 2011).

The tool consists of 17 questions, out of which the first two are the screening questions for all research designs. For example: 1. Does the study mention the research questions? 2. Do the data answer the research questions? If the answer to the screening questions is ‘No’ or ‘Can’t tell’, then the article is excluded. The remaining 15 questions are divided between the three different designs, with the rating scale of ‘Yes’, ‘No’, or ‘Can’t tell’.

The MMAT allows assessment of qualitative studies in terms of appropriateness of the qualitative approach, adequacy of the data collection process, findings and interpretations, and coherence in the research process. For the quantitative studies, appropriateness of sampling strategies, data collection measurement, statistical analysis, representation of the sample to the target population, and information about the response rate were reviewed. For mixed-methods studies, the quality criteria are: inclusion of the rationale for using a mixed-methods design, both quantitative and qualitative approaches effectively answering the research question(s), both findings being interpreted, and discrepancies between the quantitative and qualitative findings are being addressed.

All 43 studies were critically appraised. Data were extracted and synthesised from each study regardless of the methodological quality. The proforma used to extract the data included author’s name, year of publication, context, aim, methodology, key findings relevant to the research questions, and limitations of the studies (see Appendix E).

3.2.2.5 Data synthesis and integration

For this study, a convergent integrated approach was used to synthesise and integrate the data. For the details of this approach, refer to chapter two, section, 2.3.1. For the qualitative studies, a thematic analysis was conducted. This approach is recognised for use in secondary data synthesis of primary qualitative studies (Thomas and Harden, 2008). Three phases of analysis were undertaken: firstly, codes were identified ‘line by line’ from the findings and discussion sections, the development of 'descriptive themes', and the generation of 'analytical themes' (Thomas and Harden, 2008, p.4). In order to keep descriptive themes aligned with those of the primary studies, the researcher used the subscales of caring behaviour instruments. For the descriptive themes, the subscales identified were, ‘knowledge and skills’, ‘assurance’, ‘connectedness’, ‘being respectful’ from the ‘Caring Behaviour Instrument’ (CBI -24) (Wu et al., 2006), ‘comfort and trusting relationships’ from ‘Care Q-50’ (Larson, 1981), and ‘teaching and learning’ from ‘Caring Behaviour Assessment’ (CBA-63) (Cronin and Harrison, 1988). The codes were organised into descriptive themes under two analytical themes: physical care and

expressive care. For the synthesis of quantitative data, data were extracted and converted into textual descriptions or narrative interpretations to allow integration with the qualitative findings. The final stage of the thematic synthesis of qualitative data and narrative summary of quantitative data were assembled under themes to present the comprehensive findings of the review.

3.3 Results

3.3.1 Description of the selected studies

Overall, 43 studies met the eligibility criteria. Studies were conducted in different continents: 18 from European countries, 14 from Asia, including two from the Pakistani cultural context, four from America, four from Africa, two from Australia, and one from multiple countries (Philippine, Greece, Nigeria, India). All studies were published in English. Most of the studies were conducted in medical and surgical departments and others in gerontological, acute care setting, cardiac care, and rehabilitation department.

The qualitative studies (n= 19) explored the caring concept, described patient-centered care, the concept of professional care, the meaning of good care and characteristics of the nurses. The quantitative studies (n= 23) identified the highest and lowest ranking of caring behaviours and compared it among nurses and patients. One mixed-methods study explored the congruency of perceptions of nurses' caring behaviours between patients and nurses.

3.3.2 Methodological quality

At the initial screening, all 43 studies were categorised into the 'Yes' category. This means that the studies clearly addressed the research questions through the data collected. For the qualitative studies, there were consistencies between the research questions, design, data collection, analysis and interpretation. In one qualitative study by Jardien-Baboo et al. (2016), data triangulation with a number of data collection methods (semi-structured interviews, focus groups, observations and field notes) were used. Triangulation provides various perspectives on the same phenomenon and increases the credibility of the findings (Natow, 2020). There was a study conducted in the Urdu language that used back-to-back translation of the data (Rahbel et al., 2019). Piloting of the interview guide prior to using it in the study and saturation of the data were mentioned in a qualitative study (Pearcey, 2010).

However, a few of the studies did not mention the trustworthiness of the data (Pearcey, 2010; Marshall et al., 2012; Canzan et al., 2014; Modic et al., 2014; Phillips et al.,

2015; Tsai and Wang, 2015; Costello, 2017) and pilot testing of the interview guide (Edvardsson et al., 2017).

The quantitative studies had well-defined research questions with a clear sampling strategy, data collection method, and analysis plan. A few studies mentioned the reliability and validity of the instrument used from the previous studies (Mlinar, 2010; Trinidad et al., 2019; Roulin et al., 2020). Some studies calculated reliability and validity (Merrill et al., 2012; Papastavrou et al., 2012; He et al., 2013; Omari et al., 2013; Youssef et al., 2013; Kiliç and Öztunç, 2015; Flynn, 2016; Li et al., 2016; Labrague et al., 2017; Aupia et al., 2018; Fang et al., 2020; Fenizia et al., 2020; Ferri et al., 2020; Akansel et al., 2021; Allari et al., 2022). Some studies mentioned the response rate (Mlinar, 2010; Flynn, 2016; Li et al., 2016; Afaya et al., 2017; Labrague et al., 2017; Aupia et al., 2018; Fang et al., 2020; Ferri et al., 2020; Roulin et al., 2020; Akansel et al., 2021). In one quantitative study, the 'Caring Behaviour Assessment' (CBA) instrument was translated to Arabic and the researchers applied back-to-back translation (Youssef et al., 2013). In another study, a 'Caring Behaviour Scale' (CBS) was developed to collect data relevant to the Taiwanese culture (Li et al., 2016).

However, the majority of the studies did not mention pilot testing of the instruments used (Mlinar, 2010; Labrague, 2012; Merrill et al., 2012; Zamanzadeh et al., 2014; Afaya et al., 2017; Aktas and Karabulut, 2017; Edvardsson et al., 2017), reliability and validity of the instrument (Labrague, 2012; Zamanzadeh et al., 2014; Afaya et al., 2017; Aktas and Karabulut, 2017; Edvardsson et al., 2017; Thomas et al., 2019) and the response rate (Labrague, 2012; Merrill et al., 2012; Papastavrou et al., 2012; He et al., 2013; Omari et al., 2013; Youssef et al., 2013; Zamanzadeh et al., 2014; Kiliç and Öztunç, 2015; Aktas and Karabulut, 2017; Edvardsson et al., 2017; Thomas et al., 2019; Trinidad et al., 2019; Fenizia et al., 2020; Allari et al., 2022). In one study, the sample size was not mentioned (Compton et al., 2019).

3.3.3 Instruments

Most of the quantitative studies (Mlinar, 2010; Merrill et al., 2012; Papastavrou et al., 2012; He et al., 2013; Karlou et al., 2015; Kiliç and Öztunç, 2015; Flynn, 2016; Afaya et al., 2017; Edvardsson et al., 2017; Ferri et al., 2020) collected data using the Caring Behaviours Inventory (CBI-24) (Wu et al., 2006). Some studies used other instruments with similar or different subscales. However, these studies did include similar caring behaviour items within the subscales. These were the Care Q-50 (Larson, 1981) by Zamanzadeh et al. (2014) and Aktas and Karabulut (2017); Caring Dimensions Inventory (CDI) (Roger and Lea, 1997) by Trinidad et al. (2019), Akansel et al. (2021), and Allari et al. (2022); Caring Behaviour Assessment (CBA-63) (Cronin and Harrison, 1988) by (Labrague, 2012); Caring Assessment Tool (CAT-version V- 27) (Duffy, 2009)

by Thomas et al. (2019); and Caring Behaviour Scale (CBS-28) (Ou and Lin, 2006) by Li et al. (2016). One study by Fang et al. (2020) used the CARE model (Wei et al., 2018); Fenizia et al. (2020) used the Italian Caring Behaviors Inventory questionnaire; and Roulin et al. (2020) used Watson's Caring Nurse Patient Inventory-23 (Cossette et al., 2006).

In eleven of the qualitative studies, semi-structured interviews were conducted (Pearcey, 2010; Marshall et al., 2012; Canzan et al., 2014; Andersson et al., 2015; Phillips et al., 2015; Tsai and Wang, 2015; Esmaeili et al., 2016; Jardien-Baboo et al., 2016; Mako et al., 2016; Cheruiyot and Brysiewicz, 2019; Sundus and Younas, 2020). Ambrosi et al. (2021) used both semi-structured interviews and observations. Three studies collected data using focus groups (Costello, 2017; Kalfoss and Owe, 2017; Rahman et al., 2019). The remaining studies used different data collection methods. For example, Petrou et al. (2017) and Modic et al. (2014) collected data through a qualitative descriptive survey with open-ended questions. Dobrowolska and Palese (2016) used text diaries and Coughlin (2013) used participant observations and unstructured interviews. Thomas et al. (2019) used brief stories of patients and family encounters.

3.3.4 Overview of the findings as a thematic framework

The thematic synthesis of both qualitative and quantitative data was integrated to gain a comprehensive understanding of the findings, and these were grouped under two broad themes of physical and expressive care. The synthesised findings under the themes are as follows:

3.3.4.1 Theme one: physical care

3.3.4.1.1 Knowledge and skills

In several cross-sectional quantitative studies, participants reported the highest score in the subscale of knowledge and skills as compared to the other subscales (Labrague, 2012; Merrill et al., 2012; Papastavrou et al., 2012; He et al., 2013; Omari et al., 2013; Zamanzadeh et al., 2014; Flynn, 2016; Afaya et al., 2017; Aupia et al., 2018). This indicates that the nurses considered the technical aspects of care to be more important compared to expressive care.

The researchers reported different caring behaviours under this category. For instance, the nurses should have updated knowledge about patients' health conditions (Andersson et al., 2015; Kalfoss and Owe, 2017; Fang et al., 2020). This enables nurses to make rational decisions about patient care (Phillips et al., 2015; Kalfoss and Owe, 2017; Ferri et al., 2020). Further, providing updated information to patients enables them to make informed decisions (Andersson et al., 2015). Moreover, nurses

need to protect patients from harm (Petrou et al., 2017), address their needs (Pearcey, 2010; Merrill et al., 2012; Dobrowolska and Palese, 2016), and to be competent and confident in nursing skills (Merrill et al., 2012; Phillips et al., 2015). Furthermore, nurses need to fulfil patient's individual needs, which may improve their health outcomes (Coughlin, 2013; Phillips et al., 2015; Ambrosi et al., 2021). Nurses went beyond their job descriptions (Marshall et al., 2012) and provided invisible care (Canzan et al., 2014; Sundus and Younas, 2020). The next section provides a detailed explanation of these behaviours.

Based on the researcher's experience, many patients today are extremely well-informed about their health conditions. One nurse asserted that it was crucial for nurses to be knowledgeable by reading recent studies and gathering information, so that they can answer queries from patients (Andersson et al., 2015).

The professional knowledge, skills and experiences enable nurses to assess patients' needs and early identification of complications (Petrou et al., 2017). To protect patients from harm, a thorough evaluation of the patient is necessary. This could prevent a patient's life from being at risk (Tsai and Wang, 2015). In fact, coronary care nurses and student nurses reported highest scores in checking the vital signs and promptly recognising changes in the health conditions of the patient (Andersson et al., 2015; Allari et al., 2022). Checking vital signs was recognised as an important caring activity. This could help nurses to assess a patient's conditions to determine how best to manage them. However, this was considered time consuming due to the number of patients assigned to nurse (Akansel et al., 2021). In order to manage patient care, the workload of the nurses needs to be reduced. According to Zamanzadeh et al. (2014), both, first-and fourth-year student nurses demonstrated professional competency and knew when to inform the doctor about the patients' conditions. However, they were unable to anticipate the changes in the patient's condition and act accordingly. This raises concerns regarding the nurses' abilities to recognise and respond to patient need and expectations (Papastavrou et al., 2012) .

On the contrary, patients and nurses in a rehabilitation department reported highest scores on nurses knowing what to do in emergency situations and act quickly (Roulin et al., 2020). Similarly, nurses from a gerontological department anticipated patients' potential problems and to act pro-actively to resolve them (Canzan et al., 2014). A study conducted by Modic et al. (2014) investigated what patients with diabetes and nurses perceived nurses' caring behaviours to be. It was found that all six (11%) of the patients from the medical department who experienced hypoglycemia received prompt care from nurses. This clearly shows that by having relevant experience, nurses would be able to recognise and respond to changes in the patient's health conditions. Other

research has found that nurses were able to identify patients' problems and address their needs (Pearcey, 2010; Merrill et al., 2012; Dobrowolska and Palese, 2016) and that the patients seldom used their call bell to call a nurse (Coughlin, 2013). This proactive and anticipatory behaviour of nurses may help to improve the patients' conditions.

Furthermore, possessing practical competence is required to perform medical procedures correctly. This was also considered by the second-and third-year student nurses (Fenizia et al., 2020). This behaviour may ensure that the patients are safe and physical pain or anxiety are prevented. For example, one of the students in the study by Tsai and Wang (2015) shared the experience that after graduation, and continuous practice, she was able to insert a urinary catheter in a female patient who did not feel any pain. In other studies, the nurses appeared contented and confident while providing patient care (Coughlin, 2013). The patients in different departments reported that nurses were competent in giving injections and intravenous infusions (IV). Afaya et al.'s (2017) study findings showed that 91.8% of the patients from medical and surgical departments found that nurses were competent in giving injections and administering IV medication. The patients in the rehabilitation department perceived that nurses knew how to handle equipment, such as pumps and monitors and how to give intravenous infusions (Roulin et al., 2020). Both nurses and patients from the surgical department indicated that the most important caring behaviour was that the nurses knew how to give intramuscular injections and administer IV infusions. This could be because the surgical patients require more physical care at the time of their surgery (Kiliç and Öztunç, 2015). The patients from the surgical department considered that good care meant that the nurses were competent, which increased the feeling of safety, and reduced their fear (Mako et al., 2016).

Conversely, (68.79%) nurses in different in-patient departments were found less competent in nursing skills (Fang et al., 2020). Labrague et al.'s (2017) study identified that nurses from the coronary care department were less competent in skills, such as giving injections, administering IV medication, and managing and handling equipment. A study by Omari et al. (2013) explored perceptions of caring behaviours of nurses. It was found that knowing how to give injections, IV infusions, and how to handle procedural equipment were not considered the most important caring behaviours by nurses. In this study, nurses commented that competency in skills was not considered a caring behaviour; however, it is a prerequisite in nursing. Furthermore, other nurses believed that explaining procedures to patients is more important in demonstrating caring behaviours, than competency in skills. In other studies, explaining and being with patients during clinical procedures was considered the most important caring

behaviour (Akansel et al., 2021). This may help patients make informed decisions about their treatment and prepare them mentally for clinical procedures.

In addition to competency in psychomotor skills, the surgical patients emphasised the value of the nurse's decision-making abilities. They believed that the nurse's competency was inadequate when they were unable to make decisions concerning care. Inconsistency also occurred when nurses gave different responses to patients. This made them doubt the nurse's knowledge and abilities and made them wonder if they were getting the right treatment. These situations made them feel as if they could not trust nurses to give them the right care. One of the participants gave the example that nurses had differing viewpoints about an infusion: one nurse stated that the patient did not need it, but later that day another nurse came and gave him one (Mako et al., 2016).

Moreover, considering a patient's individual needs may improve their health outcomes. Each patient has his or her own needs to which the nurse should respond accordingly (Phillips et al., 2015; Tsai and Wang, 2015; Ambrosi et al., 2021). While disregarding the patient's individual needs, the nurses may not show compassionate care. This may have a negative impact on patients and may alter how they see their future interactions with the nurses (Cheruiyot and Brysiewicz, 2019). Patients in a rehabilitation department perceived the nurses to be least considerate about their individual care needs and were only interested in resolving the apparent health issues. However, the nurses thought that they considered patients as individuals and were not interested only in resolving their issues (Roulin et al., 2020). Second-and third-year student nurses responded the least to the patient's individual needs (Fenizia et al., 2020). A possible explanation for these results may be the lack of adequate education for students regarding meeting patient's individual needs in their nursing curriculum.

The findings also indicated that nurses who exhibit caring behaviours went the 'extra mile' for patient care and put in the extra effort in addition to their job descriptions and made life easier for their patients (Amy et al., 2012, p. 537; Dobrowolska and Palese, 2016; Kalfoss and Owe, 2017). This suggests that nurses were going beyond what was expected of them in the job (Marshall et al., 2012). Examples include providing 'a cup of tea', arranging a table for meal, 'bending down to tie a shoelace,' 'lighting a candle,' 'showing silent gratitude,' and asking how things were going (Kalfoss and Owe, 2017, p.537). These examples illustrate how nurses show concern and interest in the well-being of their patients and go out of their way to express caring behaviours.

On the other hand, patients and nurses believed that nurses were involved in invisible care, such as having a strong knowledge about different patient conditions (Canzan et al., 2014; Sundus and Younas, 2020). Nurses from the gerontological department

reflected and critically thought about patients' needs. They collected contextual information from the patients and planned interventions accordingly. For instance, taking care of an elderly patient with chronic obstructive pulmonary disease, who lives alone, is different from providing care to a patient with the same diagnosis who lives with family members. Nurses often reflected and changed plans according to the different situations their patient were in. Additionally, they were able to evaluate their care when they reflected on their activities following an intervention (Canzan et al., 2014).

The above section highlights visible and invisible skills that could be strengthened, specifically, having updated knowledge regarding patients' health conditions; using a proactive approach to protect patients from harm; having competence in psychomotor skills; explaining clinical procedures to the patients; increasing their ability to make decisions; and considering patients' individual needs. Some nurses went beyond their job descriptions to reflect and evaluate patients' health conditions.

3.3.4.1.2 Comfort

Considering patient's physical comfort is another aspect of physical care (Fang et al., 2020). The patients, student nurses and nurses from the coronary care, gerontological, medical and surgical departments described 'comfort' as performing daily routine activities for the patients. For example:

- Feeding, hydrating, bathing, toileting, administering medication to relieve physical pain (Merrill et al., 2012; Dobrowolska and Palese, 2016; Petrou et al., 2017);
- Providing oral care (Tsai and Wang, 2015);
- Offering things, such as blankets, position changes, back rub, lighting, keeping things within the reach of the patients, making the surrounding neat and clean before leaving the room as caring behaviours (Phillips et al., 2015; Tsai and Wang, 2015; Dobrowolska and Palese, 2016).

These behaviours make the patients feel at home. By connecting nurses, patients, their environment, and health, it is possible to create and maintain a caring environment that promotes patient well-being (Edvardsson et al., 2017). The patients from the surgical department highlighted environmental issues, such as tasteless food, and the fluctuating temperature of the room, as being important (Marshall et al., 2012). However, nurses from long-term care provided a more comfortable environment by maintaining the room temperature (Thomas et al., 2019). The study by Coughlin (2013) found that the patients were uncomfortable due to a hard bed, noise, and tasteless food. Furthermore, the pillows were not in a good condition, the ward was noisy at night

due to rattling equipment, and the food was not appropriate for cardiac patients. It was suggested by the author that nurses need to discuss environmental issues the patients are experiencing with them.

In the study conducted by Canzan et al. (2014), a female patient shared that both male and female nurses helped to maintain personal hygiene and ensured the dignity of the patients. Another study by Tsai and Wang (2015) discussed a female nurse sharing the experience that one obese male patient was unable to bend down to wash his feet, which were dirty. So, the nurse cleaned his feet. The patient smiled and was satisfied with the care. However, nurses working in a long-term care felt that they did not have time to clean and change the position of the patients (Thomas et al., 2019). A possible explanation for this might be increased nursing workload. The patients reported higher satisfaction when nurses provided physical comfort by fulfilling their basic physical needs (Tsai and Wang, 2015; Thomas et al., 2019).

To conclude, caring nurses play a significant role in supporting patients with their daily routine activities and keeping a comfortable atmosphere, such as a tidy and noise-free environment, controlling room temperature, providing high-quality meals, and comfortable bedding.

3.3.4.1.3 Assurance

These caring behaviours of nurses include ensuring patient safety, administering medication on time (Dobrowolska and Palese, 2016), monitoring the outcomes of medication administered (Akansel et al., 2021), responding to patients promptly (Marshall et al., 2012; Mako et al., 2016), fulfilling their promises (Canzan et al., 2014), giving them assurance that they are not alone in their suffering (Dobrowolska and Palese, 2016), monitoring their well-being and comfort (Petrou et al., 2017), and ensuring that their needs are addressed (Marshall et al., 2012).

In a study conducted by Petrou et al. (2017) exploring student nurses' perceptions of caring, participants described that nurses monitored their patient's progress to prevent complications. In several studies, exploring patients and nurses' perceptions of caring, the participants described caring behaviours as protecting the patients from physical and psychological harms, such as bedsores, falls, malnutrition (Andersson et al., 2015; Dobrowolska and Palese, 2016) and reducing patient anxiety while performing invasive procedures (Tsai and Wang, 2015; Mako et al., 2016). Several patients mentioned their worries about taking medications, getting treatment, or experiencing physical symptoms (Coughlin, 2013). For example, a study conducted by Ambrosi et al. (2021), illustrated that the patient was unaware of the surgery she was recommended, including details such as the reason for the operation and how long it would take to recover. The nurse reassured her that she had asked the surgeon to address her

queries. The ultimate goal for the nurse was to relieve the patient's anxiety and empower her to make informed decisions.

An example of physical harm caused by nurses was the activity of inserting IVs. For example, a study conducted by Esmaeili et al. (2016) reported a patient being frequently bruised by nurses while inserting an IV cannula. While another study noted that nurses need to work efficiently, provide safe and accurate care, and avoid making errors (Fang et al., 2020). The patient's health may be impacted by physical and psychological harm, which could lengthen their stay in the hospital. To avoid physical harm, nurses need to develop clinical skills and relieve patient anxiety by explaining the clinical procedures. Consideration of patient safety is also important. In a study by Canzan et al. (2014), one of the nurses shared the experience of informing the physician of the patient's situation at the time of discharge, as the patient did not have a caregiver to take care of him at home. That patient's discharge was postponed until the situation was resolved. Nurses in these studies appeared to ensure the safety of the patients both inside the hospital and at home.

A study by Labrague (2012) explored patients' perceptions of caring behaviours of first- and fourth-year student nurses. The patients perceived that year four student nurses administered medication on time. Another study by Labrague et al. (2017) showed that second, third-and fourth-year student nurses perceived that they administered medication on time. The patients from the medical and surgical departments also observed that nurses administered medications on time (Merrill et al., 2012). In another study, 92.9% of patient participants from the medical and surgical departments, reported nurses administered medications on time (Afaya et al., 2017). However, nurses from the rehabilitation department perceived that they did not administer the medications on time. But they closely monitored their patients and checked if their conditions improved after medications administration (Roulin et al., 2020). Administering medications to the patients on time and monitoring them may have an impact of the patient's condition.

Another study conducted by He et al. (2013)on patients and nurses, found that patients should be encouraged to call nurses in case of problems, and nurses need to respond promptly and fulfill their needs (Marshall et al., 2012; Mako et al., 2016). Ferri et al.'s (2020) study on student nurses in the first three years of the nursing programme found that students encouraged patients to call them in case of problems and responded to them promptly. The patients from the surgical department perceived that nurses were late in responding. However, the author also noted that patients seldom needed to use their call bells because the nurses anticipated patients' needs on time (Coughlin, 2013). In addition, patients admired nurses who fulfilled promises and remembered

their needs (Canzan et al., 2014). If the nurses were unable to assist the patients due to time constraints, patients felt that it was obligatory for the nurses to give reasons and inform when they would return (Mako et al., 2016). Nurses need to ensure the fulfillment of patients' needs by promptly responding to them and informing them of any delays.

In addition, the patient participants stated that knowing which nurse was responsible for providing care to them was critical in determining who to seek assistance from (Mako et al., 2016). This is important, as if patients are not informed about the assigned nurse, there can be a delay in carrying out patient care.

Nurses also provide assurance to patients that they are not alone (Dobrowolska and Palese, 2016) and help them feel safe (Tsai and Wang, 2015; Mako et al., 2016; Cheruiyot and Brysiewicz, 2019). According to the patients, a nurse should speak to them, inquire about their well-being, and keep them informed about things, for instance, about medications and plans for the day. This gives a sense of importance to the patients, as nurses ensure that patients' needs are addressed (Marshall et al., 2012) . A student described how he used to visit the patients immediately following the nursing handover to greet them, to introduce himself, to inquire about their well-being, and to get to know them a little more before beginning the activities (Ambrosi et al., 2021).

To summarise, in the literature reviewed, nurses' tasks include: preventing patients from physical and psychological harm; ensuring their safety both inside the hospital and at home; administering medications on time and monitoring its effects; fulfilling patients' needs by promptly responding to them and informing them of any delays; and visiting patients to ensure their well-being.

3.3.4.2 Theme two: Expressive care

3.3.4.2.1 Connectedness

The concept of connectedness is that regardless of the structural differences in power, patients believed that they have a mutual relationship with nurses (Marshall et al., 2012) . The caring behaviours under this theme are:

- Listening to the patients' concerns and resolving their queries (Esmaeili et al., 2016; Petrou et al., 2017; Thomas et al., 2019);
- Familiarising with verbal and non-verbal communication (Marshall et al., 2012; Costello, 2017; Fang et al., 2020);
- Using humour in conversation (Amy et al., 2012; Mako et al., 2016);
- Instilling hope in patients (Cheruiyot and Brysiewicz, 2019);
- Providing therapeutic touch for patients (Pearcey, 2010; Petrou et al., 2017);
- Advocating for patients to health care team members (Fang et al., 2020);

- Involving patients in planning their care (Marshall et al., 2012; Sundus and Younas, 2020);
- Sharing by nurses of their personal health experiences (Costello, 2017); and
- Knowing the patient by being present with them (Costello, 2017).

The findings showed that student nurses with eight weeks of clinical experience scored higher in the subscale of connectedness than those with four weeks. This could be because student nurses with less clinical experience may feel more stressed and anxious in the clinical area which influences the care they provide (Aupia et al., 2018). If student nurses have more clinical exposure, they may find it easier to bond with the patients. Other than clinical exposure, second, third and fourth-year student nurses reported the lowest scores in the theme of connectedness. This indicates that student nurses in their initial year perhaps had insufficient experience to demonstrate this behaviour (Dobrowolska and Palese, 2016).

Keeping an emotional distance from patients was a concern for the first-year student nurses. However, they perceived that nurses could build a bond with their patients without becoming too attached to them and maintain the 'professional authority' necessary for the 'nurse-patient relationship' (Ambrosi et al., 2021, p.10). Further explanation of the caring behaviours under the category 'connectedness' are presented in the next section.

A nurse should spend quality time with the patients, pay attention to their health issues and allow them to express their feelings about their diseases and life experiences (Esmaeili et al., 2016; Mako et al., 2016; Petrou et al., 2017; Thomas et al., 2019). In other studies, student nurses, nurses and patients from the medical and surgical departments rated the nurses lowest in spending time with their patients (Afaya et al., 2017; Labrague et al., 2017) and listening to their concerns (Papastavrou et al., 2012; Roulin et al., 2020). The nurse may want to support the patients, but this may be compromised because of the time constraints and busy schedules. In contrast, the study by Ambrosi et al. (2021) with the student nurses in their first year, found that they had more time to spend with the patients. For these student nurses, this was more important than giving treatment or doing anything else. The student nurses in the second and third year understood the significance of spending time with the patients, but also needed to give each patient 'the right amount of time.' This does not mean giving everyone the same amount of time, but rather giving each patient an individualised amount of time required, and attending to their needs in a way that makes the patients feel at ease and peace.

The majority of the patients in medical and surgical departments (89.1%) believed that nurses listened to them attentively (Afaya et al., 2017). Nurses in other studies also

spent time and listened to the concerns of patients (Allari et al., 2022). A study by Pearcey (2010) highlighted that nurses believed that spending time and talking with the patients was important. In spite of a heavy schedule, they should spend time with the patients to make them feel valued and satisfied. Nurses also showed caring behaviour by talking to the patients while giving them care (Dobrowolska and Palese, 2016; Thomas et al., 2019). Patients in the gerontological department valued the nurses who patiently engaged in conversation with them, paid attention to their life stories, understood their emotions and feelings without having to be told about them (Canzan et al., 2014). A study by Sundus and Younas (2020) explored the perceptions of caring behaviour of male nurses towards patients. The patients found male nurses to have good listening skills. They listened to patients' complaints and concerns and provided them with the information they needed. This behaviour may promote a good nurse-patient relationship.

Due to the critical nature of coronary disease, nurses in a coronary care department believed that listening to the patients is the most important caring behaviour because patients were more at risk of psychological distress, such as 'depression', 'anxiety', and 'mood swings', which may lead to further deterioration of heart function (Omari et al., 2013, p.3189). Nurses who avoid discussing the patients' concerns or fears, or who do not recognise things from their perspectives may lower the perception of nurses' caring behaviours (Mako et al., 2016). In a study by Modic et al. (2014), one of the nurses stated that she listened to the patients when they were not clear about the prescribed medication, or its dosage. Another nurse in this study said listening was the caring behaviour that expressed acceptance, respect, and trust for the patients. Many patients expressed a desire that nurses should spend sufficient time with them to better understand and address their needs (Marshall et al., 2012; Dobrowolska and Palese, 2016; Sundus and Younas, 2020).

A study by Ferri et al. (2020) found that the student nurses believed that communication with patients was necessary to identify their physical and psychological needs (Petrou et al., 2017). A study conducted by Thomas et al. (2019) compared the perceptions of caring behaviours of nurses and patients in a long-term care, showing patient dissatisfaction with the nurse's communication skills. Patients perceived that communication meant 'talking to', 'explaining', 'teaching', and 'informing' them about their health conditions. Nurses were aware of their verbal and non-verbal communication, such as having a smiling face (Marshall et al., 2012; Costello, 2017; Fang et al., 2020), speaking respectfully, using a low tone (Modic et al., 2014; Kalfoss and Owe, 2017; Sundus and Younas, 2020), using simple language (Jardien-Baboo et al., 2016), using humour (Amy et al., 2012; Mako et al., 2016), and giving hope to the

patients (Cheruiyot and Brysiewicz, 2019) while teaching the patients about their treatment (Canzan et al., 2014).

Nurses in the study by Costello (2017) stated that they had fun with the patients by telling jokes, which made them laugh. The use of humour is used by nurses as a coping mechanism to fulfill the emotional needs of their patients. According to patients, making jokes about various topics can help them stay positive and divert their mind from their problems (Marshall et al., 2012) . This is reconfirmed in a study by Coughlin (2013) that nurses laughed and talked with the patients. It is important that nurses exhibit friendly behaviour, are cheerful with the patients and encourage them towards well-being (Jardien-Baboo et al., 2016). Patients highly appreciated nurses when they demonstrated nonverbal gestures, such as being ‘cheerful, ‘smiling, and being happy while they worked’ (Canzan et al., 2014, p.738) .

In a study conducted by Cheruiyot and Brysiewicz (2019), it emerged that by motivating the patients to keep a fighting spirit, they assisted them in coping with impairments and overcoming any difficulty. By consistently reassuring the patients that they were making adequate progress even when they were not, the nurses created and maintained hope in their lives. By doing this, the nurses perceived that the patients would be motivated and move towards well-being. This entailed giving confidence and encouraging patients, so that they could handle their health situations. However, student nurses viewed that nurses should not use empty words, for example, 'everything will be okay’, and should not give false hope (Kalfoss and Owe, 2017, p.536). Patients perceived that instilling hope in them was least considered by the nurses from the rehabilitation department; whereas nurses in the same unit considered that they did instill hope in patients (Roulin et al., 2020). Nurses from a long-term care also inculcated hope in patients by ‘informing them about possible good outcomes’ of their disease (Thomas et al., 2019, p.198).

Patients, nurses, and student nurses from the medical, surgical, and coronary care departments rated kind and thoughtful gestures, such as touching the patients as showing caring behaviour, but thought that nurses thought this was of low importance (Merrill et al., 2012; Youssef et al., 2013; Flynn, 2016). This finding could be explained by cultural restrictions that may deter some nurses from using therapeutic touch with patients. However, nurses and student nurses from different hospital settings perceived holding patients' hands, touching their arm and forehead did demonstrate caring gestures towards the patients (Pearcey, 2010; Petrou et al., 2017). A patient shared the experience of a nurse showing her concern by placing her hand on his shoulder. He believed, she cared deeply (Kalfoss and Owe, 2017).

On the other hand, a study by Jardien-Baboo et al. (2016) indicated that a few nurses exhibited unprofessional behaviour, such as being disrespectful to the patients and shouting at them. Nurses did not listen to the patient's complaints (Coughlin, 2013). This exhibited a lack of ethical conduct by nurses, which may cause patient distress and be afraid to communicate their needs. Patients should feel comfortable and be able to talk to the nurses (Pearcey, 2010; Marshall et al., 2012). Some patients stated that male nurses were authoritarian rather than compassionate, while providing patient care (Sundus and Younas, 2020). Patients who experience poor communication may feel disregarded and neglected. Patients believed that treating them with respect at the beginning and throughout their hospitalisation gave them a great deal of confidence and comfort in a stressful environment. Patients expected nurses to greet them with a smile. A patient shared that a nurse in his ward greeted each patient individually at the start of her shift and listened to their complaints. He felt safer when she was on duty (Esmaeili et al., 2016).

Several patient participants from Fang et al.'s (2020) study believed that nurses need to be the patient's advocate. They need to connect with one or more members of the health care team to help strengthen patient's involvement in their care (Marshall et al., 2012; Sundus and Younas, 2020). Three important caring behaviours under the theme of 'advocating for the patients' included 'respecting the patient and family's best interests,' 'empowering the patient and his/her family,' and 'speaking for them.' But these behaviours were rated as least important by nurses (Li et al., 2016, p.3323).

Another aspect of connectedness is that nurses also involved patients in planning their care, such as what they needed to get done on a particular day and developed a planner accordingly (Merrill et al., 2012; Thomas et al., 2019). However, nurses in other studies did not consider this aspect of care to be important. As a result of high patient to nurse ratios, nurses may not get time to interact with the patients (Akansel et al., 2021). All the patient participants in the study by Marshall et al. (2012) said that they wanted more involvement in their hospital's care plan. One patient felt that the nurses tried to include him and other patients in the care planning process. This made him feel part of the team.

Caring also involves working in collaboration and delegating the responsibility to colleagues (Sundus and Younas, 2020). This could make things go more smoothly. On the other hand, if there is a lack of teamwork, patients may complain (Kalfoss and Owe, 2017). Nurses believed that assisting other colleagues to help the patients is important (Fang et al., 2020). Teamwork and collaboration may enable patients to receive the care they require.

The study by Costello (2017) found that nurses believed that knowing the patient was important. They emphasised the importance of being truly present for patients rather than simply rushing to finish tasks. In order to learn about patients' interests, nurses tended to ask open-ended questions about their families, home, social issues, and hobbies. Then, they began to draw out common links from their own lives. Nurses said that there were some patients who wanted to talk about motorcycles; some were interested in discussing sports and the stock market. Some wanted to discuss current affairs. It was important to identify the patients' interests in order to communicate with them (Costello, 2017). Knowing the patients was also considered important by the nurses in studies by Pearcey (2010) and Li et al. (2016). In a study by Costello (2017), one nurse shared her ostomy experiences with the patients, so that they could benefit from it. She was pregnant at that time but continued with her hobbies and job. This made them feel that they were not alone with their condition. Nurses could talk with the patients and allow them to share their interests and experiences, as well as their own.

In summary, this theme describes some expressive caring gestures, such as listening to patients and addressing their concerns. However, first year student nurses appear to lack this ability. They need to gain experience in listening to patients. Nurses make both verbal and non-verbal gestures while interacting with the patients and give patients hope to reduce the psychological distress from their illness. A nurse can advocate for patients by including them in planning of their treatment, giving them decision-making authority, and speaking out for them to the other healthcare professionals. The development of teamwork and collaboration may help meet patient needs promptly. Nurses appear to encourage patients to contribute their personal experiences and stories in addition to their own. This may help patients to feel relaxed and reduce their anxiety in the hospital setting.

3.3.4.2.2 Being respectful

The findings from the selected studies showed that being respectful means considering the feelings (Fang et al., 2020), preferences, emotions, and expectations of the patients (Labrague, 2012; Esmaeili et al., 2016; Sundus and Younas, 2020), respecting patient autonomy (and that of their families) to make independent decisions regarding their health conditions (Esmaeili et al., 2016; Li et al., 2016; Mako et al., 2016), allowing patients to actively participate in self-care activities (Canzan et al., 2014; Dobrowolska and Palese, 2016; Petrou et al., 2017), fulfilling the spiritual needs of the patients (Dobrowolska and Palese, 2016; Kalfoss and Owe, 2017; Fang et al., 2020), acknowledging their cultural values and beliefs (Jardien-Baboo et al., 2016; Petrou et al., 2017; Cheruiyot and Brysiewicz, 2019), showing empathetic behaviour (Phillips et

al., 2015; Trinidad et al., 2019; Ambrosi et al., 2021), and respecting their privacy (Trinidad et al., 2019; Roulin et al., 2020; Allari et al., 2022).

Nurses prefer to see the patients 'As the whole person and not disease, one sees the human being in the patient' (Kalfoss and Owe, 2017, p.533). The patients should be regarded and respected rather than just be considered a 'number' (Marshall et al., 2012, p.2670), an 'object', or a 'diagnosis' (Mako et al., 2016, p. 2). The patient should be 'treated as a person rather than just another patient' (Marshall et al., 2012, p.2667) .

Participants believed that nurses should treat patients in a respectful manner and be kind towards them (Mlinar, 2010; Youssef et al., 2013). Patients recognised that fourth-year student nurses were kind and considerate towards them (Labrague, 2012). In a study conducted by Mlinar (2010), the first year and fourth year student nurses stated that they were respectful to the patients and vice versa (Thomas et al., 2019). However, in Kiliç and Öztunç (2015) study, patients from the surgical department observed that nurses were not respectful to them.

Patients and families should be supported to make independent decisions regarding healthcare interventions (Dobrowolska and Palese, 2016; Li et al., 2016; Mako et al., 2016). However, in Pakistan, family members were involved in taking decisions on behalf of their relatives' treatment (Rahman et al., 2019). Patients can participate in decision-making by selecting which dietary options to choose from and which daily activities they can perform. One of the examples from a patient was that the nurse was receptive to his request to not have a urinary catheter inserted and offered to perform a bladder scan to determine how much urine was still there (Mako et al., 2016). Patients believed that making decisions without taking patient opinions into account showed disrespect or ignored their expectations. Disregarding patient preferences may be considered as an obstacle in providing quality care for the patients (Esmaeili et al., 2016). In Esmaeili et al.'s (2016) study, a patient shared that his hand was hurting so he urged the nurse to avoid putting the angiocatheter into the back of his hand, but she ignored his preference and inserted the catheter directly into the painful area, telling him that since he had already undergone such pain, he could tolerate this one as well.

According to nurses, patients are experts on their own bodies and their diseases. Therefore, respecting their decisions, preferences, viewpoints, and feelings is an important aspect of showing caring behaviour (Marshall et al., 2012; Andersson et al., 2015). Patients could keep a sense of autonomy and self-respect by being encouraged to make decisions (Sundus and Younas, 2020). However, nurses did not appear to accept patient decisions when this could endanger their health or put their quality of life at risk (Kalfoss and Owe, 2017). A caring nurse should respect the autonomy of the patients and maintain their dignity by supporting and encouraging self-care (Mlinar,

2010; Andersson et al., 2015; Flynn, 2016). For example, patients in a rehabilitation department perceived that nurses provide an opportunity to be involved in self-care activities (Roulin et al., 2020). The self-care activities include helping patients to exercise and take a bath (Canzan et al., 2014; Dobrowolska and Palese, 2016; Petrou et al., 2017). Nurses believed that, to encourage the patients to participate in his or her care, it was essential to inform them about any improvement in their condition due to their self-care activities (Canzan et al., 2014). A nurse praised the patients when they were engaged in their care (Modic et al., 2014). In Kalfoss and Owes' (2017) study, a nurse expressed that she should be mindful that even though it takes more time, she should not do things for the patient that they can do by themselves. This will result in boosting patient self-esteem and reassuring them to perform self-care activities. In Marshall et al.'s (2012) study, most of the patient participants said that they would like more engagement and communication to get a feeling of active participation in their care rather than merely being passive recipients. However, nurses were unsure about when to start enabling patients to develop independence and engage in self-care (Dobrowolska and Palese, 2016).

Another caring behaviour is to care for the patient's spiritual needs (Dobrowolska and Palese, 2016; Fang et al., 2020). Nurses provided spiritual care for patients by praying with or for them. Patients whose religious beliefs differed from the nurses still received spiritual support from them. Nurses prayed with the patients who practised other religions because they thought that it would help the patients to feel better (Costello, 2017). Patients' religious beliefs and practices are considered as spiritual needs. During their illness, Muslim patients often perform their religious practices, such as reading the Qur'an (Islam's holy book) and praying (Omari et al., 2013). However, a study conducted by Flynn (2016) identified less consideration of spiritual needs by Christian patients and nurses working in orthopedic and trauma departments.

Furthermore, identifying and providing care according to the patient's cultural background in terms of language, values, and beliefs, is also an important caring behaviour (Tsai and Wang, 2015; Jardien-Baboo et al., 2016; Petrou et al., 2017). Detachment from familiar culture and religious practices can cause spiritual distress. Language, geography, and social life are only a few examples of the characteristics that make up culture. Leininger (2002) highlights that every culture has its own values, beliefs, and traditions. Patients have the right to receive care according to their cultural beliefs and it is the responsibility of a nurse to understand and provide care that is sensitive to the patients' cultural values (Akansel et al., 2021). A nurse shared her experience about a patient whose toes were almost dropping off due to her kidney disease, but she did not consent to having her leg amputated. This patient died at an early age, but the nurse respected her beliefs (Kalfoss and Owe, 2017). In another

example, a nurse shared the experience of taking care of a vegetarian Buddhist patient whose haemoglobin was < 6 gm/dL. He did not accept the blood of a non-vegetarian, thereby putting his life at risk (Tsai and Wang, 2015, p.321).

A study by Phillips et al. (2015) examined the student nurses' personal values and beliefs at the beginning of their nursing programme. Participants in this study emphasised the importance of empathetic behaviour and felt that if this characteristic was lacking, they should not work as nurses. Student nurse participants in several studies also considered this aspect of care as important and necessary (Phillips et al., 2015; Dobrowolska and Palese, 2016; Petrou et al., 2017; Trinidad et al., 2019). In contrast, a study by Labrague et al. (2017) showed that student nurses were unable to empathise with the patients. In the study by Papastavrou et al. (2012), patients believed that nurses did not consider being empathetic to be important. However, nurses thought that they were empathetic towards the patients. This inconsistency in the rating scores between patients and nurses in this study may reflect conceptual misunderstanding or inconsistency between the nurses' perceptions and the patients' expectations regarding caring behaviour. Nurses need to show empathy by putting themselves in the patient's position. In doing so, the care that they give may be different, and they might be more sensitive to patient needs (Andersson et al., 2015; Esmaeili et al., 2016). Nurses should treat the patients as if they were taking care of a family member (Fang et al., 2020). In Esmaeili et al.'s (2016) study, a patient said that the patients should be cared for how a medical professional would prefer to be cared for if he became sick and ended up in hospital. If nurses meet even half of their patients' demands, then they may be satisfied with that care. Patients and nurses agreed that empathetic behaviour promotes a collaborative relationship between them (Rahman et al., 2019). The majority of nurses (81.53%) from different medical departments felt that they were empathetic towards their patients (Fang et al., 2020).

To conclude, nurses need to respect patients' privacy, preferences, feelings, and experiences. A nurse needs to give impartial care and should allow patients the freedom to make their own decisions and to participate in self-care activities. Disregarding patients' preferences could be viewed as a barrier to giving patients the high-quality care that they deserve. A nurse needs to approach the patients holistically, empathetically and satisfy their spiritual and cultural needs.

3.3.4.2.3 Trusting relationships

Building a trusting relationship with the patient is important (Mlinar, 2010; Coughlin, 2013). This concept describes the need for the nurses to keep the patient's information confidential (Labrague et al., 2017; Ferri et al., 2020; Akansel et al., 2021). A trusting relationship includes developing caring relationships with patients, paying attention to

their needs, and focusing on their best interests (Kalfoss and Owe, 2017). First and fourth year student nurses believed that a trusting relationship conveys a ‘Sense of commitment and understanding to patients’ (Zamanzadeh et al., 2014, p.95). Establishing trusting relationships with the patients was considered to be important by the students across all three years and they also practised this during their clinical time period (Ambrosi et al., 2021). A patient stated that building a trusting relationship would enable the patients to feel safe in the hospital setting (Coughlin, 2013; Esmaeili et al., 2016; Sundus and Younas, 2020).

Trusting relationships can be built by the nurses by introducing themselves and asking the patients to also introduce themselves. The fourth-year student nurses stated that they did not ask the patients how they would like to be addressed and failed to introduce themselves as well (Labrague, 2012). Moreover, building trusting relationships was rated the lowest by the first-and fourth-year student nurses, (Labrague, 2012; Zamanzadeh et al., 2014) and patients (Papastavrou et al., 2012). This gives the impression that certain values, such as building trusting relationships with the patients, which is rooted in caring behaviour are not demonstrated always by nurses (Papastavrou et al., 2012). It could be argued that trusting relationships may be built through the experience of taking care of patients. A study about student nurses and patients in a coronary care department rated the nurses’ ability to create a trusting relationship with the patients to be the lowest. This can be explained by the short and temporary relationship between patients and nurses in this department (Omari et al., 2013).

To conclude, building trusting relationships with patients is important. This can be achieved by nurses keeping the patient’s information confidential, introducing themselves and asking the patients to introduce themselves as well, and by paying attention to their needs. This may enable the patients to feel comfortable in a hospital setting.

3.3.4.2.4 Teaching and learning

According to Andersson et al. (2015), a nurse should provide information for patients and their families about the patient’s health conditions, treatment and how to deal with their health issues. This may help the patients participate in their own care and take informed decisions about their health problems (Youssef et al., 2013; Esmaeili et al., 2016; Mako et al., 2016).

In the study by Canzan et al. (2014), nurses stressed that occasionally the patient’s family hired a caregiver without any prior experience in providing care. Nurses got involved in the training of the caregiver to ensure the continuity of care when the patient was discharged. Even though this training was thought to be necessary, the

nurses found it to be time-consuming and stressful. However, both nurses and patients agreed that nurses did spend time with the patients to counsel them and resolve their doubts and queries (Rahman et al., 2019). Surgical patients were interested in knowing about their planned surgery (Marshall et al., 2012) , the laboratory tests and the results, and post-operative period. The findings of this study revealed that the patients were motivated by a nurse who explained these things thoroughly and patiently and helped in their rehabilitation process. Patients appreciated nurses when they kept them informed about the procedures they needed (Canzan et al., 2014). A study by Modic et al. (2014) found that 62% of the patients stated that the nurses provided information regarding the results of their blood test and kept them informed about forthcoming tests and treatments. In this study, 76% of the nurses indicated that teaching the patients was the most predominant caring gesture. Furthermore, nurses encouraged patients to ask questions, which they answered.

The majority of the patient participants in medical and surgical departments (87.4%) stated that the nurses should teach the patients (Afaya et al., 2017). Patients wanted information in a variety of formats, including verbal and in written messages (Coughlin, 2013).

In Mako et al.'s (2016) study, patients suggested that using a visual mode or a combination of all three modes: verbal, written and visual communication was more preferable. Patients in this study stated that they felt safer when a family member was briefed. Many of them felt that they should receive information without having to request it. Nurses reported the need to have the family's involvement in teaching and noted that knowing the family helped them to better understand the patients (Coughlin, 2013).

Receiving information at the time of discharge may help make the patients more independent and confident to return home. Patients tended to feel more secure after learning how to contact health care personnel once discharged. A patient who received information by the nurses regarding their stoma and its care, felt comfortable to change the stoma bag at home (Mako et al., 2016).

During teaching, nurses from a coronary care department clarified the queries raised by the patients. They also ensured that the patients understood the information given to them. Nurses also helped the patients to plan a realistic goal for their health (Omari et al., 2013), and advised them about how to achieve those goals (Youssef et al., 2013). However, cardiac patient participants stated that nurses rarely responded to their queries (Esmaeili et al., 2016). Patients felt that nurses from the long-term care department provided information for the patients but did not ask about their understanding of the information. However, in other studies, nurses believed that they

did explain and inform patients about their health condition and resolved their queries (Thomas et al., 2019).

Patients complained that fourth year student nurses did not provide any information about their care (Labrague, 2012). However, in another study, fourth year student nurses were involved in teaching the patients how to care for themselves (Zamanzadeh et al., 2014).

In summary, a nurse should provide information for patients and their families about their health conditions and treatments. This may help continuity of care when the patient is discharged, enabling the patient to participate in their own care, and make informed decisions about their health problems. It is important to ensure that the information provided is well understood. Patients also expect to receive relevant information without having to ask the nurses for it.

3.3.4.3 Factors impeding caring behaviours

3.3.4.3.1 Administrative work

The increase in administrative tasks, such as the time nurses spent on documentation and paperwork reduced the time that the nurses were able to spend with the patients (Marshall et al., 2012; Jardien-Baboo et al., 2016). Other than the administrative work, nurses may get distracted by phone calls, which hinder providing appropriate care. Since this reduces the time spent with the patients, it may be a cause of stress for the patients (Mako et al., 2016).

Poor professional care in the hospital setting may be caused by a shortage of nurses due to restricted hiring, lack of time and increased number of patients leading to increased nursing workload (Pearcey, 2010; He et al., 2013; Jardien-Baboo et al., 2016). This may lead to patient dissatisfaction about care, if their needs are not addressed in a timely manner (He et al., 2013). Patients also felt neglected when nurses were busy with their administrative tasks (Coughlin, 2013). Some nurse participants stated that they were too busy providing physical care to devote time to emotional care. The nurses who took part in Pearcey's (2010) study said they were not doing enough to keep patients safe. An example included, a patient injuring himself after falling from bed, and nurses did not see this happening. Nurses felt guilty about failing to ensure patient safety. A nurse participant said that they were not dealing with safety issues because of organisational pressures. They tended to be held accountable for the issues that were not their fault (Cheruiyot and Brysiewicz, 2019).

Nurses claimed that they did not intentionally ignore patients' needs. When they were occupied with another patient, they tried to find someone else to help. If nurses did not act immediately, they came back later and apologised for being late (Cheruiyot and

Brysiewicz, 2019). In this study, one nurse shared the experience that a patient needed a urinal, but she forgot as she had to attend an emergency call. After the call, she went back to the patient and apologised. Nurses also experienced shortage of basic things, such as soap, paper towels, which caused obstacles in the delivery of quality patient care (Jardien-Baboo et al., 2016).

In conclusion, nurses face many challenges in caring for patients. For example, time consuming documentation and paperwork, shortage of nurses, a lack of time and resources, and several patients to attend to. Because of their busy schedules, nurses may be unable to ensure patient safety and provide quality care, which may lead to dissatisfaction by both patients and nurses.

3.3.4.3.2 Social environment

The hospital environment was not very conducive for patients and nurses to interact with each other. In general wards, there was no privacy because of multiple bed settings and the presence of family members (He et al., 2013). The nurses at times felt uneasy and inconvenienced while providing care for their patients due to the presence of family members (Omari et al., 2013). The non-cooperation of the support staff can also increase the workload of the nurses, which may also hinder them in providing quality care. In addition, a lack of encouragement and appreciation from the senior management for the nurse's work was very common (Andersson et al., 2015).

Both nurses and nurse managers highlighted the importance of a positive working environment. If nurses were satisfied in their work, then there would be more positive interactions with the patients. Nurses believed that a positive working environment meant working in a unit where nurses in charge respected them and provided them with additional support staff when required (Pearcey, 2010; Jardien-Baboo et al., 2016).

In brief, some social circumstances may also make it more difficult to give care to the patients. For instance, the nurses may experience anxiety when delivering care while family members are present or face difficulties due to lack of support and cooperation from the senior management. A positive work atmosphere should be promoted by appreciating the work of nurses, increasing the number of nurses and minimising the workload, thereby enhancing more effective interactions with the patients.

3.3.4.3.3 Patient behaviours

Nurses demonstrated caring behaviours, however, some studies found that patients were unappreciative and undervalued them (Dobrowolska and Palese, 2016). In Tsai and Wangs' (2015) study, one of the nurses described how the patients continually treated her rudely and disrespectfully. She felt upset and nearly wanted to give up

nursing. In Cheruiyot and Brysiewiczs' (2019) study, patients from a rehabilitation department occasionally were demanding, annoying, and irritating. A nurse gave the example of a patient calling her and asking for a urinal. This prompted other patients to ask for the same. Patients were aggressive with that nurse and shouted at her. Nurses disregarded or refused to care for the demanding or challenging patients. The participants acknowledged the need to put emotional barriers between themselves and the patients to avoid interacting unprofessionally with the patients in stressful situations. Nurses admitted to ignoring the difficult patients sometimes, but eventually they went back to them because they knew that they were accountable for the care they provided.

3.3.4.3.4 Nurses personal issues

Student nurses believed that nurses may experience terrible days and experience fatigue just like everyone else (Jardien-Baboo et al., 2016). In Dobrowolska and Paleses' (2016) study, student nurses felt a lack of independence at work, or that they simply lacked information about how to provide effective care. Sometimes, they also felt that the pay structure was unsatisfactory. At times, the nurses also faced personal and family issues. All these factors could also hinder the delivery of quality patient care (Pearcey, 2010).

3.4 Discussion of phase one

This mixed-methods systematic review has synthesised the perceptions of caring behaviours among patients, nurses, and student nurses. The mixed-methods approach allowed the development and comprehensive understanding of the caring phenomena. A review of the qualitative studies provided an in-depth and richer explanation of the phenomena. The quantitative studies provided data with ratings of the descriptors of caring behaviours.

In this review, caring is described in two themes: physical and expressive care. Some key findings under these themes and their relationships with other studies will be discussed in the next section.

3.4.1 Physical care

3.4.1.1 Knowledge and skills

The current review found that participants across a majority of the studies rated the knowledge and skills of nurses the highest. This finding is consistent with the finding of the previous quantitative systematic review based on 29 studies, which compared the perceptions of caring behaviours among nurses and patients (Papastavrou et al.,

2011). It is also in line with the findings of the studies (Bowers et al., 2001; Tuckett et al., 2009) cited in the previous mixed-methods systematic review based on 12 studies (seven quantitative and five qualitative), which identified the quality of a good nurse (Van der Elst et al., 2012, p.95). Nurses were unable to provide expressive care because of a shortage of nurses and the time constraints (Marshall et al., 2012; Dobrowolska and Palese, 2016; Jardien-Baboo et al., 2016; Cheruiyot and Brysiewicz, 2019). However, patients may not expect to receive expressive care from nurses until their basic physical care needs are fulfilled (Papastavrou et al., 2011). Physical care includes feeding, hydrating, bathing, toileting (Merrill et al., 2012; He et al., 2013; Petrou et al., 2017), changing a patient's position (Thomas et al., 2019), and providing oral care (Tsai and Wang, 2015) . Older patients from the studies included in the previous literature review, considered that physical care included helping them take a bath, assisting them to the toilet, and offering a bedpan or urinal in a timely manner (Wilde et al., 1994; Larsson and Larsson, 1997; Smith and Sullivan, 1997; Bowers et al., 2001; Tuckett et al., 2009, cited in Van der Elst et al., 2012, p. 95).

3.4.1.2 Prompt care

The findings from the studies included in this review showed that nurses encouraged the patients to call in case of problems and, that they should respond to calls quickly (He et al., 2013; Ferri et al., 2020). These findings corroborate with those of the studies included in the previous review (Hudson and Sexton, 1996; Santo-Novak, 1997; Smith and Sullivan, 1997; Marini, 1999; Bowers et al., 2001 & Tuckett et al., 2009, cited in Van der Elst et al., 2012, p. 95).

3.4.2 Expressive care

3.4.2.1 Communication with patients

The findings indicate that effective communication with patients means spending quality time with them, which allows them to express their feelings about their condition and life experiences (Phillips et al., 2015; Esmaeili et al., 2016; Mako et al., 2016; Petrou et al., 2017). These findings are consistent with the studies (Wressle et al., 2006; Tuckett et al., 2009) included in the previous review (Van der Elst et al., 2012, p.95). However, studies included in the current review reported that student nurses, nurses, and patients from the medical and surgical departments believed that the nurses usually did not always spend time with the patients or listened to their concerns (Papastavrou et al., 2012; Labrague et al., 2017; Roulin et al., 2020). Pearcey (2010) explained that these results may be due to a shortage of nurses, which can compromise the time required to deliver expressive care. In the study by Jardien-Baboo et al. (2016), participants stated that there were nurses who exhibited

unprofessional behaviour such as being rude to the patients. Patients and their relatives complained about the manner of interactions with the healthcare professionals in the health care setting. These behaviours may threaten patient dignity and result in the dissatisfaction with the nurse's behaviour (Jangland et al., 2009; Nadzam, 2009). Therefore, nurses need to act professionally in their interactions with patients and their relatives.

3.4.2.2 Protecting patients from psychological harm

Nurses need to protect patients from psychological harm, such as reducing anxiety while performing invasive procedures (Marshall et al., 2012). According to the previous review by Papastavrou et al. (2011), nurses did not identify patient anxiety and depression. They also did not give the patients enough time to convey their concerns. A caring nurse knows how to talk to patients in simple terms about their disease, treatment plan, and the side effects of their medications. This helps to alleviate their fears and anxiety (Poole and Rowat, 1994; Sexton, 1996; Hudson and Santo-Novak, 1997 & Wressle et al., 2006, cited in Van der Elst et al., 2012, p.95).

3.4.2.3 Respecting patient autonomy

A nurse needs to respect the dignity of the patients by involving them in planning their care such as reported by Thomas et al. (2019). They also involved the patients in preparing their timetables which may help the patients understand more about their own care when the information is discussed at the bedside handover. This could increase the patient's involvement in their own care, improve outcomes, increase satisfaction with the care, and strengthen the patient's trust in the care given by the nurses (McMurray et al., 2011; Kerr et al., 2014).

Moreover, patients and their families should be allowed to make independent decisions (Li et al., 2016; Mako et al., 2016). Nurses need to maintain patient dignity by supporting and encouraging them about self-care, in addition to appreciating their involvement in self-care activities (Flynn, 2016; Mlinar, 2010). The findings in this review indicated that when nurses provided information related to the patient's health conditions, treatment and how to deal with the health issues, it appeared to help the patients and their families participate in self-care and make informed decisions (Modic et al., 2014; Youssef et al., 2013). According to the previous review by Van der Elst et al. (2012), patient participants in the studies (Poole and Rowat, 1994; Hudson and Sexton, 1996; Marini, 1999; Robichaud et al., 2006; Wressle et al., 2006; Westin and Danielson, 2007), perceived that patients should be encouraged to self-care. This can be accomplished by educating them, showing them how to take care of themselves (Hudson and Sexton, 1996; Larsson and Wilde, 1997; Smith and Sullivan, 1997) and,

by allowing them to make informed decisions (Larsson and Wilde, 1997; Smith and Sullivan, 1997) (p.95).

3.5 Implications of review findings

The findings of this review contribute to a body of knowledge related to caring behaviours in the field of empirical evidence. It defines caring and related behaviours that help nurses meet patient expectations. However, much of the literature was from a Western culture where different expectations on the part of nurses and patients may not necessarily transfer to the Pakistani cultural context.

In this review, only two studies were found from Pakistan. One study explored and compared the perspectives of health care providers, including nurses and others regarding patient centered care in an orthopaedic department of a private tertiary care hospital (Rahman et al., 2019). The findings may not be transferable to the target population because patients were getting free-of-cost services from the hospital and their responses may be biased because of these facilities. The findings from the private hospital may not be transferable to the public hospital because of the differences in their resources and infrastructure.

The second study explored patients' perspectives regarding caring behaviours specifically pertaining to male nurses in the medical and surgical departments of three private tertiary care hospitals (Sundus and Younas, 2020). The study findings may not be transferable because the researchers explored perceptions of patients about caring behaviours of male nurses only and did not provide more knowledge about patients' expectations of care by female nurses. In Pakistani culture, nursing is primarily a female profession and being caring has been regarded as a quality of a female nurse (Younas and Sundus, 2018; Asif, 2019; Arooj et al., 2022). There is limited data on female nurses working in the hospital, however, as discussed in the chapter one, section 1.2.5, majority of the nurses working in the hospitals are females.

In this review, deficits in knowledge and training requirements of both nurses and student nurses have been identified. The review's findings in this first phase of the thesis provide a foundation to explore patients, nurses, and student nurses' perceptions of caring behaviours within various medical and surgical departments of both public and private hospitals in Pakistan.

3.6 Strengths and limitations

Through a mixed-methods systematic review, an in-depth insight into the perceptions of caring behaviours among patients, nurses and student nurses was attained. This review followed the Joanna Briggs mixed–methods systematic review approach (Lizarondo et al., 2017). PRISMA (Page et al., 2021) was used to report the process of the selection of the articles. All three reviewers screened each title and abstract of the selected articles, and any discrepancies about inclusion of the articles were resolved. One reviewer (the Researcher) independently extracted the data, performed the analyses, and generated the themes. The other two reviewers (PhD supervisors) reviewed the extracted data, analysis, and themes. A mixed-methods appraisal tool (MMAT) was used to appraise the methodological quality of the studies to help assess quality standards for differing research designs (Hong et al., 2019).

Some limitations of conducting this review were: the exclusion of the studies focusing on the perceptions of caring behaviours by the participants working in emergency departments, palliative care, community, and primary care. Secondly, the selection of studies in the English language only, and thirdly exclusion of perceptions of family members and other health care staff. By excluding these some potentially significant contributions in this area could have been missed. In addition, the MMAT only provides a qualitative appraisal of a study which may limit the overall quantitative rating of each study (Hong et al., 2019).

3.7 Chapter summary

This mixed-methods systematic review explored the perceptions of caring behaviours among patients, nurses, and student nurses. Both the qualitative and quantitative studies highlighted the importance of physical and expressive care; however, the expressive aspect of care is often neglected by the nurses. At the initial stage, student nurses were more interested in improving their physical skills as compared to the expressive skills. With ample clinical experience, expressive skills were further improved. It may be argued that nursing educators emphasise the physical aspect of care in the early stages of training (Zamanzadeh et al., 2014). Nurses consider knowledge and skills to be the most important aspects of caring; being knowledgeable means that nurses should have updated knowledge and competences in nursing skills. This brings confidence in their performance, enables them to assess patients' needs, and helps them to make rational decisions. It is emphasised that the patients should be made comfortable as if they were at home by assisting them in taking meals, bathing, toileting, changing position, and by keeping their environment neat and clean. Nurses

need to be aware of making the physical environment comfortable by providing quality food, comfortable beds, and by maintaining the room temperature. The nurses also need to ensure the safety of the patients by protecting them from physical and psychological harm. Nurses should monitor the patients' progress and assess whether the medication has improved their health condition.

Nurses should effectively communicate with patients and resolve their concerns. Conversing with the patients helps to relieve their anxiety. This also helps to build a respectful and trusting relationship with patients. Effective communication between the nurses and the patients may improve the nature of care given and provide quality outcomes for the patients' health. Involving a patient in planning their care and giving them some control over it may increase their satisfaction with the care provided. Due to poor communication, patients may feel disrespected by the nurses and discomfort with the hospital environment. Nurses can share their personal health experiences with patients, so that they can learn from those experiences. Nurses should advocate patient concerns to other members of the health care team and work in their patients' interests.

There were conflicting findings regarding instilling hope in the patients. Some nurses provided false hope about their progress; others did not give false hopes; while some discussed positive news only. Due to cultural restrictions for both patients and nurses, some nurses do not touch patients while communicating with them. However, other nurses as part of the caring behaviour did physically touch the patient, for example by holding hands or touching the shoulder.

The findings revealed that nurses should respect the patients' feelings, experiences, preferences, and expectations. The participants in the studies included in this review emphasised that a nurse should show compassionate and empathetic behaviour towards patients. The patients and their families should be supported to make independent decisions regarding healthcare related interventions.

Nurses should maintain patient dignity by supporting and encouraging them in self-care activities, such as exercising and bathing. Moreover, considering the spiritual and cultural needs of the patients is also considered as an important caring behaviour.

Culture may also influence the patients' values and beliefs regarding their health and adherence to the treatment. Patients admitted in the hospitals come from diverse cultural backgrounds and nurses need to provide care and manage their health issues according to their beliefs and preferences. It is suggested that the nursing curriculum should also incorporate intercultural teaching to enable nurses to provide culturally sensitive care to a diverse population.

The findings also showed that nurses could build a trusting relationship with their patients by maintaining confidentiality of information and by addressing them appropriately. Ensuring that student nurses and nurses build a trusting relationship is essential for enhancing caring behaviour.

Delivering information to the patients and their families regarding their health condition is also important. This may help them to participate in their own care and make informed decisions regarding their care. Nurses can use different aids to teach patients such as verbal, written, and visual methods. Nurses also need to seek feedback from the patients about whether they have understood the information given to them.

Nurses found contextual challenges that impeded showing caring behaviour towards patients. For instance: an increase in the administrative tasks, shortage of nurses, non-cooperative support staff, and lack of encouragement and appreciation from their seniors.

In conclusion, all these findings indicate that the nurse educators need to strengthen the expressive aspect of care among the student nurses (Li et al., 2016). A nurse needs to develop knowledge, attitude, and skills for an effective nurse-patient relationship, so that patients' needs are met.

Chapter 4

Phase two: Qualitative exploratory-descriptive study design

4.1 Introduction

This chapter provides an overview of phase two by explaining the exploratory-descriptive qualitative design used for this study. The chapter provides a detailed method of the study used, including sampling, a description of the study's ethical considerations for phase two, the recruitment process, and data collection strategies. It also focuses on the framework of the data analysis approach and the conclusion of the study. The findings and a discussion are presented in a chapter five.

4.2 Methods

A research design or method is a comprehensive plan for carrying out a study. This entails determining the feasibility of the study as well as selecting research strategies that answer the research questions related to the phenomena under consideration. The research strategy comprises of the analysis of population, sampling strategy, setting, method of data collection, duration of the study, method of data analysis, findings, and recommendations (Gray et al., 2016).

4.2.1 Sampling

4.2.1.1 Study population and setting

The study participants were patients, nurses, and student nurses, from public and private hospitals, and nursing colleges because they represent the diverse organisations in Pakistan and provide information about the research phenomena. The study was conducted at a private and a public nursing college and tertiary care hospitals in Islamabad, Pakistan, over a period of four months-December 2021 to March 2022. The rationale behind selecting these colleges was that they are in the capital city of Islamabad and that the selected nursing colleges offer Bachelor of Science in Nursing (BSN) and Post RN-BSN programmes. The selected nursing colleges recruit students from different regions of the country. The selected private hospital is a teaching hospital and is certified by the Joint Commission International Accreditation (JCIA). The public hospital is one of the major hospitals in the public sector. The two hospitals provide services to patients from different areas of Punjab and other regions. Patients get free treatment in the public sector, whereas in the private sector, patients have to pay for the treatment. The selected institutions are different in terms of their resources including the physical infrastructure, the number

and quality of professionals, and management policies and procedures. The participants were chosen on the following eligibility criteria as shown in table 7.

Table 7: Eligibility criteria

Study participants	Rationale for inclusion
Inclusion	
• Registered nurses having more than six months of experience • Student nurses studying in BSN (3rd and 4th year) and Post RN-BSN (1st and 2nd year) • Patients from the medical and surgical departments • Able to speak Urdu or English language • Public and private hospitals and colleges	• Nurses involved in direct patient care or bedside care • Student nurses have the clinical exposure to direct patient care • Registered nurses in these departments provide general care to the patients • These two languages are spoken frequently • To get a variability of data from two different institutions
Exclusion	**Rationale for exclusion**
• Participants exclusively working in Emergency, Palliative Care Community, and primary Care • Head nurse and administrator • Student nurses from BSN programme (1st and 2ndyear) • Patients too ill	• These areas require special care such as technical and long-term care. • Nurses who do not have direct patient contact • Limited clinical exposure • Unable to take part in the study

The researcher selected student nurses from third and fourth year of BSN, and first and second year of Post RN-BSN programmes of different age groups and genders. Nurses from different medical and surgical departments, had different years of experience, qualifications, and different age groups. Adult patients from different medical and surgical departments, age groups, genders, qualification, and number of hospitalisations, were selected. In addition, the researcher used snowball sampling, which is also called chain sampling or network sampling. After the first participant, the researcher asked other participants to suggest those who had similar experiences and might be interested in taking part in the study (Howie, 2013).

Although other stakeholders such as nursing faculty, head nurses, and nurse managers could have been recruited, the participants for this study were recruited as they were thought to be more suitable candidates because of their involvement in bedside care. This would allow them to reflect upon their own the perceptions and experiences of caring behaviour.

The sample size is usually between 12-25 (Grove and Burns, 2012) for qualitative studies. However, in this study, the sample size was not predetermined, and data collection continued until saturation. There are four categories of saturation:

Theoretical saturation: when repeatedly similar categories are found. This empirically assures that saturation has occurred in the categories (Fusch and Ness, 2015).

Data saturation: this meant that interviews continue until no new information emerges from the participants (Sandelowski, 2008; Carlson et al., 2010; Francis et al., 2010; Speziale et al., 2011; Polit and Beck, 2012; Hill et al., 2014; Jackson et al., 2015; Middlemiss et al., 2015). This type of saturation occurs overall at the data set. However, saturation is also achieved at the individual level. The researcher needs to keep probing until they believe that they have reached saturation and fully understand the participant's perspective (Legard et al., 2003).

Inductive thematic saturation: this focuses on in-depth analysis of the data and emergence of different codes or themes (Hennink et al., 2017). According to Hennink et al. (2017) relying on this type of saturation may miss the point of saturation or completeness or meaning of codes.

Priori thematic saturation: where pre-determined theoretical categories are taken to analyse the data (Hennink et al., 2017).

Out of these four categories of saturation, the researcher used the data saturation technique and continued with the recruitment until no new information emerged from the participants. The further details of the data saturation are provided in the recruitment section.

4.2.2 Ethical considerations

4.2.2.1 Ethics and research governance approval

Approval of research from an ethics committee is required to conduct research (Ritchie and Lewis, 2014). Ethical approval was obtained for phase two of the study in January 2021 from the Institutional Review Board and Ethical Committee (IRB-EC) of Shifa Tameer-e- Millat University (STMU), Islamabad and from the School of Healthcare Research Ethics Committee (SHREC) at the University of Leeds, reference HREC 20-001. The Shifa IRB Board is authorised to review studies involving patients and nurses from Shifa Hospital, as well as student nurses from the university. Moreover, to collect data in the public hospital and the nursing institution, a request letter along with the IRB approval letter was sent to the department head for permission to approach the potential participants.

4.2.2.2 Key ethical considerations

A verbal and written explanation of the purpose of the study, risks and benefits of participation in the study, maintenance of privacy of the data, voluntary participation, and withdrawal from the study were shared with the participants (Grove et al., 2012). For written explanation, a participant information sheet (PIS) in Urdu or English as appropriate was provided (see Appendix G). The participant information sheet provided necessary information to the participants to make an informed decision about voluntary participation in the study by signing the consent form. The researcher explained about the study to the patients and nurses in-person and to the student nurses online. The researcher explained to the participants that there was no potential risk for their participation in this study. It was also explained that while there are no direct benefits for the participants involved in this study, the findings may enhance knowledge and understanding of the importance of caring in practice by nurses. This may change the nurses' perceptions of caring and improve patient care. Furthermore, the participants were provided with an opportunity to ask any questions about the study. All the participants were given a minimum of 24 hours after sharing the PIS to decide if they wished to take part in the study.

The participant's autonomy was ensured and negotiated with them. When obtaining consent, the participant was informed about the research, why they were selected, and how the interview would be conducted. The consent was therefore obtained without coercion and following a clear explanation (Franklin et al., 2012).

The consent form for voluntary participation, specifically highlighted the safeguarding of the data, and the right to withdraw from the study (Ritchie and Lewis, 2014), during and up to one week after data were collected (see Appendix H). The participants were asked to note this deadline as it would not be possible to remove their data once analysis had begun. The consent form was given to the participants either in person or online and was available in both English and Urdu.

Before starting the interview, the format of the interview was again explained to the participants. Furthermore, due to the dual roles of the interviewer as a nursing professional and a researcher, participants were given a thorough explanation of both the roles to prevent confusion among the participants (Houghton et al., 2010).

The interviews were audio-recorded with the permission of the participants. This enables the researcher to capture the participants' responses, while allowing the researcher to focus on the relationship and interaction with the participants (Maxwell, 2013). The researcher was objective and impartial while collecting data from the participants. The researcher also tried to reduce the distance from the participants by creating an 'anti-authoritarian relationship' (Råheim et al., 2016). As participants were

sharing their experiences of being cared for, or giving care, there was a possibility that during these interviews, the participants may become upset. It is essential to avoid employing therapeutic techniques to alleviate psychological distress. It is emphasised that one should know their own boundaries and stay within the role of the researcher. However, in specific circumstances in the research setting, a health professional may be required to switch from being a researcher to becoming a therapist role (Dickson-Swift et al., 2006). The researcher must make the appropriate referrals if the interviewee shows signs of needing therapeutic care (Murray, 2003).

To protect the participants from harm or discomfort (Polit and Beck, 2012), the researcher as an experienced nurse would have been able to give support to any participant and would have stopped the interview until the participant wished to continue. However, if it became necessary, the researcher, with the permission from the participant would have informed the nurse-in charge (for patients and nurses) and the year coordinator (for student nurses) and provided information on counselling services and other services within the hospitals. However, in this study, all the participants were comfortable with the interviews and no further intervention was required.

Breaching confidentiality and violation of privacy of the participants may occur when interviews are conducted online. Furthermore, it is important to ensure the quality of internet (Chiumento et al., 2018). However, there was no risk of breaching the confidentiality of participant's information while conducting the interview online; because it was conducted at home in a separate room without any interruption from their family members. The quality of the internet including its stability and speed was excellent throughout the interviews.

To ensure privacy, all the data were kept confidential. Only essential demographic data were collected from the participants. The participants' identities were only known to the researcher. To ensure confidentiality, each transcription was anonymised by using numeric and alpha I.D codes. For example, for the first student who was interviewed from the private sector, the code ST-PR-1 was used. Similar codes were used for each group (Fry et al., 2011). To comply with data protection requirements and confidentiality (Shamoo and Resnik, 2015), all the information was protected by using a password protected file. All the study paper documents were kept in a locked filing cabinet. Only the anonymised data were accessible to the PhD supervisors.

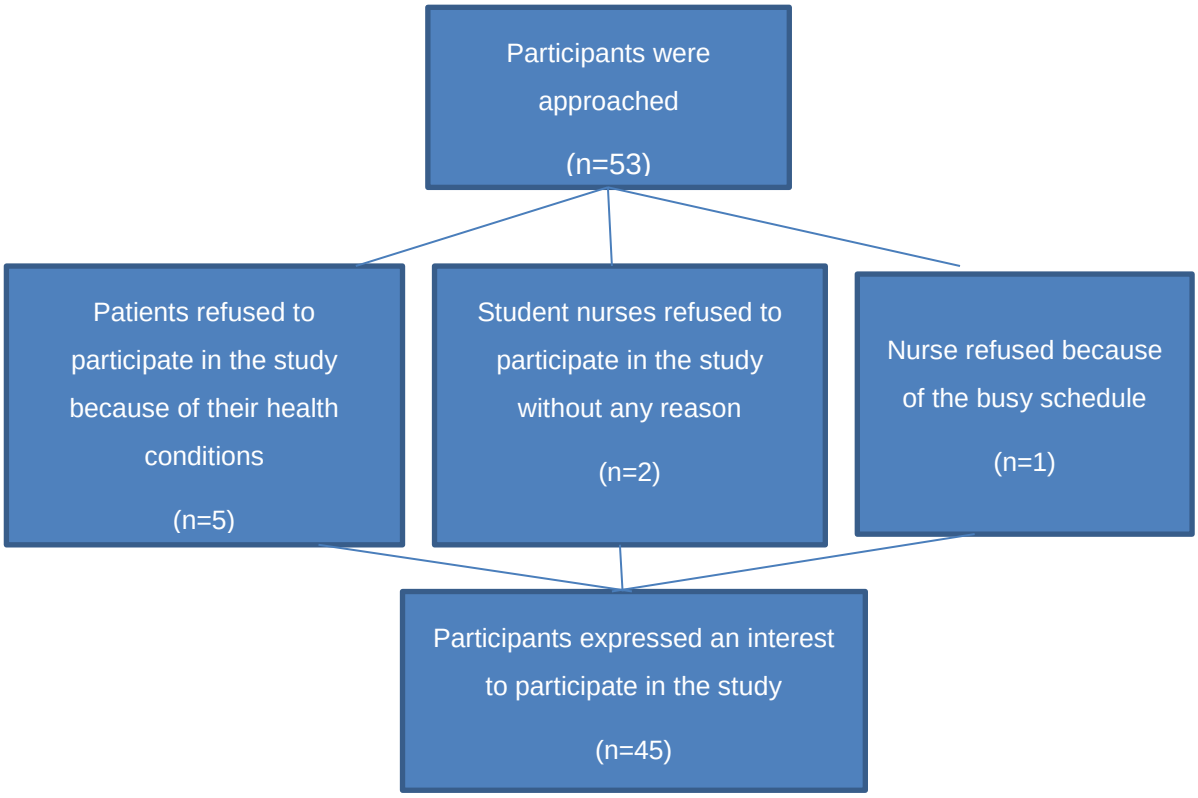
A plan was developed for the organisation and storage of the data. Electronic files of interview recordings, transcripts, and demographic information were uploaded on the University's cloud storage system (one drive). Cloud storage is one of the storage systems which allow the access to the data using internet (Gray et al., 2016). All the

confidential information would be destroyed after five years in accordance with the University of Leeds policy and Data Protection Act 2018.

4.2.3 Recruitment

After ethical approval of the study from the Institutional Review Board (IRB) of Shifa Tamer-e Millat University and the University of Leeds, permission was taken from the nursing colleges and the hospital heads to approach the participants. In the public and private hospitals and nursing institutions, a request letter along with the IRB approval letter, a sample of the participant information sheet, and a consent form were sent to the departmental heads. After getting approval from the departmental heads, the primary researcher met with the managers in the hospitals and the year coordinators of the nursing programmes and obtained the list of potential patients, nurses, and student nurses, based on the inclusion criteria. The researcher used maximum variation as part of the purposive sampling method for this study. Moreover, due to the potential language barriers, participants who spoke their native language and the English language were recruited to take part in phase two. For the recruitment of the participants, an email was sent to the student nurses. The nurses and patients were approached face to face. In total, 53 participants were approached. Five patients refused to participate in the study because of their health conditions. Two student nurses refused to participate in the study without any reason. One nurse refused to participate because of the busy schedule. Finally, 45 participants expressed an interest to participate in the study (see Figure 8).

Figure 8: Flow chart of the recruitment of participants



Recruitment stopped when data saturation occurred at 42 interviews. This was established through recurrence of responses and that there was sufficient data to recognise, nuances, meaning, themes and patterns in the data (Hennink et al., 2017). Data saturation was determined within the individual participant and across all three groups. However, three more interviews each with patient, nurse, and student nurse were conducted to verify or validate that there were no new information or themes emerged from the data, or any data gaps. At this point data saturation was confirmed (Jassim and Whitford, 2014; Vandecasteele et al., 2015; Creswell and Creswell, 2018). The final sample comprised of 13 student nurses, 15 nurses, and 17 patients.

4.2.4 Data collection

A semi-structured interview approach was used to collect in-depth data for the study. Interviews included face-to-face interactions in which the researcher obtained information from a variety of people (Rubin and Rubin, 2012; Seidman, 2013). Unlike quantitative interviewing, qualitative research interviewers are research instruments themselves (Kvale, 2007; Marshall and Rossman, 2016). Semi-structured interviews allow enough information to be elicited and patterns to be detected because the same questions may be asked of all of them. However, they do not have to be done in the same order (Richards and Morse, 2002). Individual interviews allow researchers to acquire rich and in-depth information from participants to better understand their personal viewpoints and contexts on topics of interest (Ritchie and Lewis, 2014).

According to Ritchie and Lewis (2014), in-depth interviews place a variety of demands on an interviewer's intellectual abilities. First, the interviewer should listen, assimilate, and interpret the participants' responses. Second, the interviewer needs to be able to distil the key aspects of a participant perspectives and make decisions about what to investigate. Third, having a good memory is a valuable skill. It is important to make a mental note of a point raised by the participants earlier in the interviews and return to it at a later point in the conversation to seek clarification or elaboration. Furthermore, the interviewer should exhibit a desire to understand the participants' points of view and build a positive relationship with them. When the interviewer tries to put the participants at ease and create a trusting environment, a healthy working connection is formed. In addition, exhibiting interest and respect, flexibility in responding to the participants, exhibiting understanding and empathy are all important aspects of building rapport with them.

4.2.4.1 Development of topic guide for semi-structured interview

Richards and Morse (2002) recommend that open-ended questions for semi-structured interviews should be designed in advance. For the interview with patients, nurses and student nurses, the researcher devised three sets of topic guides for the semi-structured interviews. However, the questions were altered to fit the roles of the participants. For example, to explore the spiritual care aspect, the researcher asked the patients, “How do nurses fulfil your spiritual needs during hospitalisation?” From nurses, “How do you provide spiritual care to the patients?” The topic guide was developed as follows (Kallio et al., 2016).

Initially, the purpose of doing in-depth interviews for data collection was identified. Secondly, the existing literature related to the study topic, the perceptions of caring behaviour, was reviewed. Thirdly, an interview topic guide was formulated based on the literature review. Following Ritchie and Lewis (2014), content mapping was done by identifying the key dimensions and topics to be explored such as ‘caring’, ‘caring behaviour’, ‘spirituality’, ‘cultural care’, ‘advocacy’, ‘counselling’, ‘expectations of patients’, and ‘autonomy.’ Along with this, content mining was considered in which questions were designed to explore the meaning within each dimension. This approach helps to get in-depth rich information related to phenomena under study.

The appropriate length of the interview guide was based on seven to eight separate topic questions (see Appendix F). In the fourth step, to check the clarity of interview questions, the interview guide was piloted on three participants, one from each group, to verify clarity of the questions. The participants in the pilot interviews understood the questions and no modifications were required in the interview topic guide. For practice, the researcher also conducted interviews with colleagues who had prior interviewing experiences (Munhall, 2012). These rehearsals assisted the researcher in identifying any issues in her technique before beginning the study. Practice sessions and pilot interviews can also help to estimate the time required for an interview (Rubin and Rubin, 2012). Furthermore, the researcher attended an online training course on how to conduct qualitative interviews, organised by the ‘Social Research Association’, on September 10, 2020.

The transcripts of piloted interviews were then reviewed by the supervisors. They were not included in data analysis because the interview technique needed some improvement to include more probing and follow up questions, to explore valuable insights.

Data were collected between December 2020 to March 2021, by the primary researcher through face-to-face and online using the topic guide. At the time of the interview, only the researcher and the participant were present.

The participants gave permission to record the interviews which enabled the researcher to capture the participants' responses, while allowing her to focus on the relationship and interaction with the participants (Maxwell, 2013).

The researcher dressed appropriately according to the cultural context of the participants, while collecting the data to reduce any unnecessary influence on the participants when interacting with the researcher (McCurdy and Uldam, 2014).

While collecting the data face-to-face, health and safety regulations, made by the hospital management, related to COVID-19 (CV-19) or any other infectious diseases, were complied with. This included wearing a face mask, maintaining social distance, regular hand washing with soap and water for at least 20 seconds, or otherwise using hand sanitiser. No data were collected from CV-19 patients in the hospital settings as these patients were kept in a separate unit. For face-to-face interviews, the interviews were conducted in different settings including colleges and hospitals. The privacy of the participants was considered. These interviews were conducted separately with 13 nurses and 17 patients, in the conference room of the hospitals, and with four student nurses, in the conference room of the college. However, because of the job and academic commitment of some nurses and student nurses, and CV-19, interviews from two nurses and nine student nurses were conducted online through Google Meet at a mutually convenient time.

The researcher began the interview by asking the participants if they had any questions or reservations about the study or the interview, and then proceeded to obtain their consent for the interview. The researcher then collected the participants' demographic information by using a demographic data form (see Appendix F). The form included gender, age, educational background, institution, and hospital departments. For patients, number of hospitalisations and for nurses, experiences were also included. This information gave an overview of the characteristics of the study population (Creswell and Clark, 2017). Then the interview questions were discussed and explained to the participants for better understanding and overcome their anxiety about the interview.

The researcher used a diary to jot down key points, or any significant nonverbal gestures witnessed during the interviews. According to Ritchie and Lewis (2014), during the interview different probing techniques can be used. The researcher used unplanned probes such as silence and amplification to encourage the participants to

elaborate further to get an in-depth understating of the phenomenon, for example, “Which behaviour do you like the most?”

Exploratory probing was used to explore feelings and views that lay behind the behaviour or experience in order to understand the meaning, for example, “Why do you think caring is important?”; “How did you respond when patients were aggressive?”

Explanatory probing was used to explore reasons and explanation of participants’ views, for example, “What impedes nurses caring behaviour?”

Clarification probing was used to clarify the terms or languages being used, for example, “Could you please explain, “what do you mean by mental agony?”

Furthermore, one response triggered multiple points for probing. Immediate points were addressed first and then the earlier points were dealt with. For example, “You said earlier, nurses should have charm and spark… Can you further explain?”

The researcher maintained interest and attention towards the participants by maintaining eye contact, occasional smiling, nodding and asking follow-up questions. This signals the participants to continue sharing their views, which are relevant and valuable.

The data collection and analysis were performed simultaneously to identify significant concepts, gaps in data and data saturation points (Polit and Beck, 2012; Gray et al., 2016; Creswell and Clark, 2017). Based on the analysis of the three transcripts of each participant of the main interviews, gaps led to the development of additional questions such as:

“How do you develop hope in the patients?”

“What are the characteristics of a caring nurse?”

“Why is caring important?”

“How do nurse educators emphasise caring behaviour in the students?”

“What teaching strategies can they use to teach caring behaviour?”

The average length of the interview was 30 minutes each with the range of 10-60 minutes. The amount of time depended largely on the amount of information the participant was willing to share as well as the need for probing and further information.

The researcher transferred the data from the recorder to the computer after each interview and saved the interview as a voice file using numeric and alpha I.D codes as explained in this chapter, section, 4.2.2.1. In the analysis and discussion, the researcher used the same I.D codes.

4.2.4.2 Data transcription and translation

All data transcription was done word by word using Microsoft Office Word software (MS Word) by the researcher, which enabled complete and thorough understanding of the data obtained (Gray et al., 2016). Transcriptions took three to eight hours for each hour of the interview (Marshall and Rossman, 2016). Different punctuation marks were used to express different nuances.

As most of the data were in native (Urdu) language, they were translated into English by the researcher and were reviewed by a second translator. Both translators were able to converse in the original and target languages and were familiar with the ideas covered in the research (Chen and Boore, 2009). According to Chang et al. (1999), the researcher's involvement in data translation helps to gain a deeper understanding of the individual's experience and its underlying meanings.

Back translation is the process of translating from the target language (English) to the source language (Urdu) and back to the target language (English) so that the equivalence between the two versions may be assessed (Chang et al., 1999).

Translation and back translation procedure (Chen and Boore, 2009), was as follows:

1. Initial verbatim draft in Urdu language was translated into English. Being a bilingual, researcher translated the text, which was checked by a bilingual translator.
2. The content analysis of preliminary drafts of Urdu and English versions were done, and concepts and categories were identified.
3. The concepts and categories in Urdu were translated into English and back-translation was done.
4. Finally, the concepts and categories created from the Urdu and English data sets were compared. The researcher asked the bilingual translator to review and confirm this process.

The involvement of the bilingual translator helped to validate the translation of the general content. The findings demonstrated that the same categories emerged from the analysis both Urdu and English data sets (Chen and Boore, 2009). Furthermore, following this process, researcher tried to keep the categories representative of the meanings constructed by the participants (Wong et al., 2020).

4.2.5 Data analysis

The framework approach was used to analyse data (Ritchie and Lewis, 2014). The stages of the framework data analysis are described in table 8.

Table 8: Stages of the framework data analysis

Stages	Actions taken
Data management	• Familiarisation of the data • Transcribed the interviewed data • Read and re-read the transcribed interview and verified with recordings to make sense of data • Codes grouped together and developed categories • Categories also grouped together into broader categories • Developed a coding matrix • Constructing an initial thematic framework • Developed the coding index to organise the data
Descriptive Analysis	• Coded data were summarised, synthesised, and initial themes and categories were refined • Abstract concepts were created by finding association between themes
Explanatory analysis	• The researcher began reflecting on the original data and the analytical steps to ensure that participants' beliefs and experiences were precisely reflected and to minimise misinterpretations • Interpreted the findings, explore meanings, and explain the concepts and themes • Explored the relationship between the core concepts and themes through the theoretical perspectives relating to the perceptions of caring behaviour • Generalisability of the findings

4.2.5.1 Data management

For familiarisation with the data, the researcher became immersed in the interview data by transcribing them, to gain an overview of the important content, and to ensure that labelling was supported by data. To ensure that the data were accurate, the interviews were played and listened to twice, and the transcripts and field notes were read. Listening to audio recordings helps the researcher to be completely immersed in the data (Patton, 2015). Immersion implies that you are completely absorbed in the data and have spent a significant amount of time reading and thinking about it.

Data analysis may be done manually or by using software. For this study, the transcripts were organised, and the initial coding and categories were developed on NVivo. Further refinement of categories and themes was done on MS Word.

The textual data was read line by line to grasp the meaning of the data. In order to summarise what the participants were describing, codes and categories were created by considering each line, phrase, or paragraph of the transcript. Initially, the key phrases were taken from the participants' own words ('in-vivo' codes) and preliminary thoughts were developed. The framework method recommends in-vivo coding to be 'true' to the data. After that, the initial categories were developed, and coding matrix was generated (Ritchie and Lewis, 2014). Table 9 illustrates an example of a coding matrix, showing the steps needed in determining codes and their meanings.

Table 9: Coding matrix

Interview transcripts	Description (in-vivo codes)	Preliminary thoughts (what is this about?)	Initial categories
ST-PR-7, female student **Programme: BSN** **Year of study: 4th Year** **Age: 22** **Institution: Private** …'So, patient and family does consider that nurse is readily available for them for the help and should be very uh humble and respecting their opinion and listen to them...'	Readily available for them for the help and should be humble and respecting their opinion.	Nurses spent time, listen to the concerns of the patients, and resolve them.	Give priority to their concerns Respecting patient's opinion Resolve patient's issues
PA-PR-7, female patient **Department: Surgical** **Institution: Private** **Qualification: Bachelor** **Hospitalisation: 3rd** **Age: 38** 'I would prefer that nurses listen to my concern. If they are not providing time, they are not listening to my concern, what is	I will prefer that nurses listen to my concerns	Nurses should provide time to listen patient concerns	Listen to patient concerns

happening with me; at least they listen to my concern.'			

4.2.5.2 Develop thematic framework: Identifying initial categories or themes

The coding matrix was developed from 45 interview transcripts, which seemed to represent a range of perceptions and experiences of the participants. To ensure rigour, coding matrix and transcripts were reviewed by the supervisors. Changes in the coding matrix were made by the supervisors and recorded to the margins of the matrix. In the beginning, in-vivo codes developed potential categories. The categories were further grouped according to their conceptual similarities and differences into broader categories as they progressed. Furthermore, similar categories were clustered to develop initial themes. The 'coding index' was developed based on the initial categories and themes, which enabled to organise the interview data. However, as new insights appeared during the data analysis, the coding index was modified. An example of a coding index is shown in Table 10.

Table 10: Coding index

Initial categories	**Initial themes**
Pay attention to patient concerns Resolve patient's issues	Resolve patient's issues

4.2.5.3 Descriptive and explanatory analysis

The coded data were summarised and synthesised. The researcher repeatedly reviewed the data and validated the initial categories and themes that were anchored in participants' descriptions (Ritchie and Lewis, 2014). New insights appeared during the data analysis and the initial categories and themes were refined. An example of the development of refined category, theme and concept is shown in Table 11.

Table 11: Developing the concept

Initial categories	**Initial theme**	**Refined category**	**Final theme**	**Concept**
Pay attention to patient concerns Resolve patient's	Resolve patient's issues	Solve the problems	Meeting patient physical needs	Professional knowledge and skills

issues				

For the explanatory account, the researcher began reflecting on the original data and the analytical steps to ensure that participants' beliefs and experiences were precisely reflected. Through using the framework approach, eleven core concepts with the themes were developed that appeared to reflect the participants' accounts. These will be explained in detail in chapter five, 'Study findings and discussion.' Finally, the researcher explored the relationships between the key findings against the wider literature related to the perceptions of caring behaviours, which will be further explained in section 5.3.3 of chapter five.

In conclusion, having a sufficient sample, ensuring that data collection procedures are consistent with the study's purpose, and having clear data analysis process may all contribute to the research's credibility (Sandelowski, 2000). Transparency in data analysis can be achieved by documenting the entire process of data analysis and the generation of final themes and concepts. While other researchers may interpret the data differently, understanding and comprehending how the themes and concepts were generated is critical to establishing the robustness of the findings (Noble and Smith, 2014). Finally, the eleven concepts along with their themes were examined by the supervisors to ensure coherence with the participant data (refer Chapter five, section, 5.2.2).

4.2.6 Researcher reflexivity

Reflexivity means reflecting on our own biases, beliefs, values, and personal experiences, and how these shape the interpretation of the data. Factors such as background, gender, ethnicity, and qualification of the researcher also impact the interpretation of the data (Creswell, 2013; Ormston et al., 2014; Patton, 2015; Bryman, 2016; Marshall and Rossman, 2016). Reflexivity is important to ensure objectivity and neutrality in a qualitative study (Gray et al., 2016). To prevent personal prejudice over the phenomenon from entering the data analysis and interpretation processes, I maintained a reflective journal. In a reflective journal, the researcher writes about their past work experiences (Creswell and Clark, 2017). This strategy helps to maintain objectivity and to mitigate the risk of influencing the study findings (Ritchie and Lewis, 2014). The current thesis project was conducted from a neutral viewpoint, without bias or opinion.

Past clinical experiences

After completing the nursing diploma and Post RN-BSN, I worked in the private hospitals in both medical and surgical departments in Pakistan. I have eight years of experience in clinical setting as a bedside nurse. While interacting with patients, I heard them say on many occasions that the nurses are not behaving well. They are rude and impolite with patients and their relatives. It is my own observation that most nurses do not show a caring attitude. They just carry out the regular and routine tasks and completed documentation, mostly focusing on physical care and not providing emotional care. While handing over and throughout the shift, I also found nurse's communication to be poor. But I was committed to providing proper nursing care for the patients and tried to fulfil the patient's emotional and physical needs. But sometimes, I was unable to fulfil my own basic needs, such as taking a meal break.

Experience of data collection

Before data collection, I thought that participants would not cooperate; they would not want to give their time and share information. However, I did observe that participants had trouble difficulty expressing their thoughts because of the abstract concept of the study. But they tried and did give me valuable information to help develop the educational programme for nurses. Some patients refused to participate in the study without any reason, and overall, the patient participants were less expressive and vocal, which resulted in shorter interviews with some of the participants in this group.

The patients appreciated the service provided by the nurses. They felt that sometimes things were delayed because of a shortage of nurses and their heavy workload. The workload inhibited the available time that the nurses had to spend in patient care. I found this to be contrary to my own experience of nursing care explained above.

I also observed that there were two to three nurses in the hospital unit and busy giving medications to the 50 patients. Because of the low nurse/patient ratio, nurses were unable to give medications on time, especially, analgesia. They did not check if the intravenous fluids were being administered properly or fluids were replaced when the bag was full. In Pakistan, it is common for a separate technician to be assigned to change the dressing of all the patients and I observed technicians using unsterile techniques. Nurses were also talking loudly at the nursing station.

When I interviewed nurses and student nurses at my own institution, the role of the participants and me as a researcher needed consideration. The participants were informed that in this context, I was not an employee of the institution, but a PhD scholar, so they can be free to share information confidentially. During interviews, the

participants did not appear to be influenced by my position and the data were therefore, not compromised.

The clinical experiences of the researcher may have impacted the findings of the study. Nonetheless, trustworthiness criteria was followed for the valid and reliable findings, the implementation of framework analysis, along with the review of final themes and concepts with the supervisors ensured that the findings accurately reflected the participants' views (Coughlin, 2013).

4.3 Chapter summary

This chapter has discussed the methods of the exploratory-descriptive qualitative study design. Ethical approval was obtained from the two institutions: SHREC and STMU – IRB-EC to conduct the study. This chapter also discussed the key ethical considerations for phase two. The use of purposive sampling strategy to select the study participants and ensure maximum variations of data has been explained. The patients, nurses, and student nurses were selected from both public and private hospitals and institutions to investigate the perspectives of the caring behaviours. The final sample comprised 45 participants. Data were generated through semi-structured face-to-face interviews using a topic guide. The topic guide was used to make sure that the participant interviews remained focused on the topic and address the research questions. Using framework analysis enabled data to be explored systematically and transparently by documenting the data analysis process. In the following chapter, the findings and a discussion are presented in detail.

Chapter 5

Phase two: Study findings and discussion

5.1 Introduction

The aim of this phase of the study was to explore the perceptions of patients, nurses, and student nurses regarding nurses' caring behaviours in Pakistan. The study findings and analysis are presented in this chapter. The foundation for developing the findings is to address the research questions (Bryman, 2016) and summarise, evaluate, analyse and synthesise the evidence (Pyrczak, 2016). The narrative approach is used to present the findings of the analysis. Quotations were extracted from the participant interviews, based on their feelings, opinion, and experiences. These were used to describe and demonstrate the nuances and complexities of the study phenomenon (Creswell, 2013). The findings are discussed in the final section which explores the interpretations of the findings.

5.2 Findings

5.2.1 Characteristics of the participants

A total of 53 participants were approached, out of which 45 participants expressed an interest to participate in the study (see Figure 8). Most of the patients were male (59 %). Eleven out of seventeen participants were between 31-59 years of age, and from the surgical departments of the private institution. Nine participants were admitted multiple times to the hospital. Seven participants had matriculation only (completed secondary school with a certificate), nine participants had a bachelor's degree, and one had a master's degree.

Most of the nurses were females (73%). Nine out of fifteen participants were in the range of 31-59 years, working in a public hospital, and seven had a Bachelors in nursing degree. Eleven participants had more than two years of clinical experience.

Most of the student nurses were females (54%). Nine of thirteen participants were between 20-30 years of age and nearly seven were in placements in the public and private institutions. The student nurse sample had three from BSN year three; four from year four; and two from Post RN-BSN year one and four from year two.

Table 12: Demographic characteristics of patients

Characteristics	Number of participants (%) Patients	Number of participants (%) Nurses	Number of participants (%) Student nurses
Gender			
Male	10 (59 %)	4 (27%)	6 (46%)
Female	7 (41%)	11 (73%)	7 (54%)
Age (years)			
20-30	4 (23 %)	6 (40 %)	9 (69%)
31-59	11(65%)	9 (60%)	4 (31%)
>60	2 (12%)	N/A	N/A
Department			
Medical	6 (35%)	7 (47%)	N/A
Surgical	11 (65%)	8 (53%)	N/A
Institution			
Public	6 (35%)	10 (67%)	6 (46%)
Private	11 (65%)	5 (33%)	7 (54%)
No of times hospitalised			
Once	8 (47%)	N/A	N/A
Multiple	9 (53%)	N/A	N/A
Qualification of patients			
Matriculation	7 (41%)	N/A	N/A
Bachelor	9 (53%)	N/A	N/A
Master	1 (6%)	N/A	N/A
Qualification of nurses and student nurses			
Diploma in Nursing	N/A	4 (27%)	N/A
Bachelor in Nursing (BSN)	N/A	7 (47%)	N/A
Year III	N/A	N/A	3 (23%)
Year IV	N/A	N/A	4 (31%)
Post-RN Bachelor in Nursing (Post-RN BSN)	N/A	4 (27 %)	NA
Year I	N/A	N/A	2 (15%)
Year II	N/A	N/A	4 (31%)
Clinical experience (years)			

<2	N/A	4 (27%)	N/A
>2	N/A	11 (73%)	N/A

5.2.2 Overview of the findings as a conceptual framework

Eleven overarching concepts emerged from the analysis of participants' accounts of their perceptions and experiences of caring behaviour. All these themes are representative of patients, nurses, and student nurses. These concepts and associated themes are presented in Table 13 and are described below using excerpts from the participant interviews to illustrate each theme.

Table 13: Core concepts and themes

Core concepts	Themes
Human trait	• Commitment and compassion • Caring as a personal value
Showing interest in patient health	• Maintaining a caring environment • Protection from harm • Promoting mental well-being
Professional knowledge and skills	• Knowing the patients • Meeting patient physical needs • Being appreciated by patients and relatives • Competency in nursing skills
Consideration of spiritual needs	• Assessing and facilitating spiritual practices • Encouraging patients to have hope
Culturally sensitive care	• Respecting patient values and beliefs
Interpersonal relationships	• Building a trusting relationship • Therapeutic communication skills
Role in supporting and educating patients	• Meeting patient expectations • Characteristics of a nurse • Providing reassurance to patients • Barrier to educating patients
Supporting patients to be independent	• Assessing patient needs • Empowering patients to self-care • Supporting patients' decision
Unethical behaviour of nurses	• Communication skills • Practical procedures • Provision of information
Challenges to caring behaviour	• Nurses workload • Lack of appreciation from senior nurses • Use of technology • Behaviour of patients and relatives • Nurses personal issues

	• Reciprocity
Teaching strategies	Teaching strategies

5.2.3 Narrative of the findings

5.2.3.1 Human trait

This concept is concerned with how participants perceived caring as a human trait. The participants from all three groups perceived fulfilling their responsibilities to the patients, being loyal to the patients, resolving issues immediately, and upholding promises made to patients as the main aspects of caring. However, caring is a skill that may be learned through practise. This concept is supported by two themes: commitment and compassion and caring as a personal value.

5.2.3.1.1 Commitment and compassion

The majority of participants across all three groups reflected that nurses should perform their work responsibly and vigilantly. They should be fully committed to providing quality care for their patients and can do this if they are dedicated. For example, one of the student nurses described commitment as fulfilling responsibility in physical tasks such as administering medication:

"Nurses should be responsible. Responsibility means never missing any dose of medicines. It is the biggest responsibility whichever medicine has been prescribed by a physician or doctor…" (ST-PU-1)

The student nurse from the public institution considered being a responsible nurse was shown by not missing any dose of medication. However, a patient from the private hospital expressed it as providing treatment on time. The patient expressed:

> She has to be responsible for the work. If they are willing to work, they can go for the best… So, it is all about dedication. They should be responsible for medication, the best medical services, and on-time delivery of all these medical services… (PA-PR-4)

The nurse's commitment to work and being loyal to the patients were seen as important aspects. A nurse reported feeling satisfied after being sincere in the delivery of care. The following quote from a nurse exemplifies this:

> It is very important to be afraid of God that He is watching you whatever you are doing. Whatever I have done so far, I have done it with full commitment and loyalty. I have always made sure that whatever time I spend in the hospital, I

> serve with full dedication and when I go back home, I am fully satisfied and have a sound sleep. I have never received a single call from the hospital about any issue when I am home. (SN-PR-5)

There were also broader understandings of compassionate care by a student in a private institution and this was illustrated through nurses keeping promises to patients and resolving their issues immediately:

> If I say something to the patient, 'Ok I will do it, you are in pain, I will give you injection,' and they [nurses] say 'I am coming' and they get busy with other work. The patient keeps ringing the bell, without any response and the patient is still in pain, what are we doing? I try to make sure to solve their complaints or resolve their problems as soon as possible [turning face to the right]. (ST-PR-1)

On the contrary, a nurse from the public institution suggested compassionate behaviour can be demonstrated by educating the patients about their health condition. For example, a nurse said:

> People should take time to talk and guide them [patient] about their disease. We should show more love to the patients. If patients want information, we should provide that and not disappoint them. (SN-PU-15)

Furthermore, respecting the patients and treating them with the same dignity as nurses would expect to be treated themselves is important. Participants from all three groups found nurses to be skilled but felt that what makes a good nurse is empathetic behaviour. Nurses can provide better care if they understand the experiences of the patients. Patients thought the choice of words nurses use when communicating with them was important, for example, one student nurse explained:

> Compassionate uh for me showing concern and kindness towards others. In my point of view, caring is considering you want others to treat you with the same dignity and respect. For me that is caring. (ST-PR-1)

Showing empathetic behaviour means that nurses put themselves in the family member's or patient's position. A nurse said:

> Without empathy, we cannot have caring behaviour. So uh, if the nurse will have an empathetic feeling for a patient, that nurse will always do good for the patients, the best, whatever he/she can do. So, empathy means making a patient or we can say [long pause] if we keep ourselves in patient's shoes, this

> means we think of every patient as our own father or mother in that place, or my sister in that place. So, what can I do at that time... (SN-PR-3)

One of the patients talked about the choice of words while communicating with the patients which may show that the nurses empathise with the patients:

> [Micro pause] uh empathise is like, for example, pain relief, right…. You [patient] call them [nurses] that '… I am having too much pain. So, I need uh a pain killer or injection.' …So, it's a simple choice of words you reply to the patient. They [nurse] can say, 'I understand uh that due to your partial nephrectomy, you are facing a lot of pain, right. And this pain will be there for a while and uh we will try our best to relieve …ur pain. I am gonna consult with your doctor and come back to you quickly, as soon as possible.'

The patient further said, "These are simple choices of words that show that the person empathises with the patient. I don't see empathy in the nurses here because I guess they are never trained, but overall attitude has been good…" (PA-PR-3)

The findings reflect the golden rule of ethics of reciprocity, which state that if you want others to treat you with respect, you must treat them with respect as well (Greetham, 2006). Other reflections from all the participants around commitment and compassionate care include nurses not missing medication rounds, the timely provision of treatment, resolving the patient's issues, informing patients about their health condition, keeping promises with the patients, showing empathetic behaviour, and being loyal to them. Furthermore, a person can learn caring through their life experiences. The next theme describes this aspect of caring.

5.2.3.1.2 Caring as a personal value

One of the student nurses provided a very different aspect of the human trait: caring as a personal value. In this interpretation, the student believed that every nurse appears to have their own set of values that guide their actions. In addition, an individual might learn to care for others through their personal experiences with patients. For example:

> I think it all starts with a person and my ethical values and how I am going to apply these. Every person has a different value, and every person will apply it differently. So, my values will be different from yours. Caring is something that you are not born with. You learn from time to time. (ST-PR-5)

According to the student's beliefs, caring can be demonstrated based on the nurse's personal values or feelings about patients. Furthermore, caring can be learnt through clinical experiences. A nurse needs to show personal interest in the patient's health

conditions and acknowledge their experiences. It is equally important to provide physical and psychological comfort as well as to keep the patients safe from harm. The participants' perceptions of caring behaviour within the concept of showing interest in patient health will be explored in the next section.

5.2.3.2 Showing interest in patient health

Showing interest in patient health was described as the way in which nurses take care of their patient's emotional needs and how they show friendly behaviour towards them. It also encompasses providing physical comfort by keeping the environment neat and clean and protecting them from physical and psychological harm. This concept is supported by three themes: maintaining a caring environment; protecting from harm; and promoting mental well-being.

5.2.3.2.1 Maintaining a caring environment

Caring for patients entails expressing care for them by enquiring about their general health and how they feel. A nurse should cultivate a culture of friendliness in the environment. If they create a friendly atmosphere for the patients, this helps them to feel good and share their concerns. The patients shared their experience of how nurses showed interest towards them by enquiring about their health condition, *"They [nurses] ask me, How do you feel now? How is your health?" (PA-PR-10)*; *"She [nurse] asks, "Are you feeling better. Do you have pain?" (PA-PU-11)*

Nurses need to behave in a friendly manner to put the patients at ease. As one of the patients explained, *"And if we are cheerful with nurses, they should also respond in the same manner. This is in our culture, [ethnic]. In our culture, maybe people are serious…They should be friendly." (PA-PR-9)*

One of the nurses also considered the importance of a friendly environment. As a result, patients can be open pertaining their concerns without fear of being judged. She shared, *"I am friendly, so without hesitation they share their concerns. We should create a friendly environment." (SN-PU-14).*

One of the patients expected that nurses should respond to the patients humorously and she exclaimed, *"And if we are humorous with nurses, they should also respond in the same manner. This is our culture, but many are serious. They do not want to involve themselves, like in joking." (PA-PR-9)*

Nurses should have the sense of humour that helps to develop bonding with the patients and release their stress. A student nurse expressed her views, *"Uh a caring*

nurse can make patients laugh by telling them good jokes. This also releases stress of the patients and builds bond with them." (ST-PR-3)

Findings from the student participant, who felt that nurses can provide care at that level so that patients can relax in the hospital and feel as if they are in a family environment reiterated:

> Like if the patient is sick and his/her family is praying for the nurse because of her care, then appropriate care should be given to them [patients]. So, they get to relax in the hospital environment and feel at home. (ST-PR-2)

Nurses need to establish a relationship with the patients to relieve their stress. One of the student nurses said, *"Uh, a caring nurse can make patients laugh by sharing general news or common events. This releases patient's stress and builds a bond with them." (ST-PR-3)*

The need for nurses to communicate with patients in a friendly manner while educating them regarding their treatment plan also emerged from the findings. This had the aim of ensuring that the patients would comply with the treatment, resulting in improved mental well-being and physical conditions. One of the student nurses revealed:

> …Instead of giving them rigid instructions or orders, we deal with them in a friendly way. In this way, the patients will also accept that we are talking for their betterment. If you create a friendly atmosphere with them, the patients easily accept the environment and start feeling good. If they are mentally happy it will affect their physical condition. (ST-PU-1)

Providing a caring environment also means showing warmth and respect towards patients. This may help nurses to have a positive impact on a patient's conditions. Besides this, it is also important to care for the patient's physical environment, such as keeping it neat and clean, noise free with appropriate lighting and temperature. One of the students claimed, *"The environment should not disturb the patient, noise, lighting, temperature. These things are necessary to bring the patients to a comfortable zone..." (ST-PU-2)*

The above extracts expressed how the environment can be kept comfortable by maintaining the temperature of the room, proper lighting, and a noise-free atmosphere. The patient perceived that keeping the hospital rooms neat and clean was important. However, care for patients also appeared to be different in the public and private sectors as a patient exclaimed:

> I saw nurses in a public hospital. There is only one nurse who only gives medication. Here [private sector], nurses not only give medication, but if your room is untidy, I am surprised; your male nurse changed my bed sheet. Although it was dirty, he picked the dirty sheet, emptied urine bag and we could feel the smell. My urine bag was emptied by a female nurse. These are the things that groom the organisations and make the person satisfied. (PA-PR-5)

This finding showed that in the private institution, nurses carried out a wider range of tasks, such as changing the bed sheets and emptying the urine bag to keep the environment neat and clean. However, in the public institution, these activities are more likely to be carried out by a housekeeping person. The next theme discusses the necessity of protecting patient safety and health by assessing and preventing the patients from any adverse effects associated with healthcare while they are in the hospital.

5.2.3.2.2 Protecting from harm

This theme encompasses safeguarding the patients from any adverse effects associated with health care such as falls, infection, dehydration, air bubbles in IV tubing, and psychological distress. This student nurse described:

> …if I am giving care to the patients, I'll do it in a way that doesn't cause any harm to them. They won't cause them any harm, like if I do not give proper care, it will affect their health… If I treat them wrongly then I may affect their life and not only their life, but their families, because of my mistakes… (ST-PR-2)

It is important that a nurse is vigilant in responding to the patient's needs, thus trying to prevent any harm and assist with speedy recovery. A nurse pointed out:

> So, if I am given duty in a ward or anywhere and a patient comes in with the complaint of dehydration or continuous infusion has started, so, my main responsibility would be to focus on his dehydration level and try to improve his condition so that he can quickly recover. If someone is on infusion, so I need to make sure that the normal saline that he is taking is replaced before the first one finishes so it is not filled up with extra air that could harm the patient. (ST-PU-1)

To protect patients from getting infection in hospital, a nurse felt that sterile or aseptic techniques should be used. One of the nurses stated, *"We need to provide proper care to the patients. Regarding skills, nurses should use sterile technique for any procedure. However, in hospital settings, nurses neglect this aspect of care." (SN-PR-4)*

It was viewed that nurses needed to ensure that patients are protected as much as possible. They appeared to provide special care and attention to the patients who are at high risk of falling. For instance, a patient submitted:

> Yesterday, a nurse came to me and put a red band on my wrist and said, 'Because you are weak, we should not leave a patient alone. In the hospital, we put this because you have had a surgery and should be given extra care. We want to prevent you from falling when you get out of bed.' (PA-PR-5)

The above quotes reveal the importance given to preventative care. In addition, supporting patients experiencing psychological distress was also highlighted by participants from all three groups. Examples of these include patients feeling distressed due to their disease, some personal issues, uncaring behaviour of the nurses, new hospital environment, and being unaware about the treatment plan. For example, one of the nurses perceived that patients were affected by other issues such as psychosocial distress and complained:

> Sometimes patient's psyche is disturbed because of the disease process…They may go into depression if we do not treat them nicely, if we do not talk to them humbly, they will be more down. They will not improve because they are upset. Sometimes, they are not supported by their families or relatives maybe their relatives are not good to them. Sometimes, they are alone and unattended, nobody is with them. (SN-PU-7)

According to the findings, one of the student nurses said that patients may have anxiety about the new hospital environment and the financing of their medical treatment. She said, *"The patients have different insecurities as the hospital setting is a new atmosphere for them. They are uncertain about the treatment plan, financial budget, and health improvement." (ST-PR-7)*

Furthermore, findings revealed that the patients were not always informed about their treatment plan which might cause them to be anxious. A student nurse stated:

> … They [patients] don't know what's going to happen. They don't know what the doctors are planning. Most of the time, they don't know what would happen in the next hour, the next 2 hrs. They [nurses] are saying, they will do something in an hour and then it's been 2-3 hrs, things still do not happen. Nobody is telling, why there is a delay or why the procedure happened or not when it's going to happen. Now that increases the anxiety of the patients… (ST-PR-1)

The above quotes indicate that circumstances, such as personal, family, and hospital environment can lead patients to experience psychological discomfort. This could have an impact on the patient's health. The nurses in this study believe that it is the nurse's job to alleviate pain and improve their health. The following section will look at how nurses should assist patients in reducing emotional suffering.

5.2.3.2.3 Promoting mental well-being

This theme discusses the perceptions of the nurses and patients regarding the different ways they promote patient well-being. The participants proposed different strategies to relieve patient stress. For instance, by supporting the patients to be well-informed regarding their treatment plan, they become mentally prepared for the treatment regime. One of the patients spoke about being kept informed about a medical procedure by a nurse and reported:

> So, they just give us information on what would happen next. Of course, a patient knows in advance. So, the patient can adjust accordingly. Or he is mentally prepared, now next thing, I am going to get this, IV drip or uh next thing, I am supposed to have uh probably a lab guy taking a sample. So, you are mentally ready. (PA-PR-3)

Likewise, informing about the effects of medication, as discussed by one of the nurses:

> …I am going to administer pain killer medication to a patient, so the first question will be asked by the patient, 'When will I get relief from pain. The injection which you have given, how long does it take to get effective?' So, when you are giving an injection then simultaneously talk with them. You can say, 'the injection which I am administering you, will relieve your pain soon'… (SN-PU-8)

The findings revealed that using diversional therapy may relieve the patient's stress. One of the students suggested, *"Nurses can use diversional therapy that helps patients to divert their minds from their current situation, so the patients don't think about the trauma they are going through."* On enquiring about what is diversional therapy, a participant explained, *"In diversional therapy, you keep them engaged with their favourite hobby. Like, he has an interest in book reading or painting or he likes to watch television. So, you can keep him busy by talking about their favourite hobby…" (ST-PR-1)*

The hospital environment may be challenging for the patients. To reduce patient's anxiety, a nurse can orient patients to the hospital environment:

> So, uh what I have observed is that [micro pause] most patients in the healthcare setting are under stress, you know, they feel, it's a different environment to be in a hospital…helping them to understand the environment, how things work around here… (ST-PR-1)

This theme has provided an understanding of how to improve patient care by becoming more conscious of the pain and suffering that their patients are going through.
It is also important for nurses to provide care in line with their professional knowledge and skills, including performing their skills efficiently and appropriately. The concept of professional knowledge and skills will be explored in the following section.

5.2.3.3 Professional knowledge and skills

The concept of professional knowledge and skills emerged from the data and is supported by four themes: knowing the patients; meeting patient needs, being appreciated by patients and relatives, and competency in nursing skills. All participants highlighted the importance of getting information about the patient's health conditions, expertise in performing certain skills, timely and prompt provision of care, utilisation of updated knowledge and use of logical reasoning in patient care.

5.2.3.3.1 Knowing the patients

Knowing the patients is described as having complete information about the patient's health conditions that is essential for the nurses to identify their needs. One of the patients suggested, *"They should have complete knowledge about the patient. For getting information, they should talk to the patient, which is very necessary. They should assess the patient's needs… she also learns from the patients…" (PA-PU-15).*

Furthermore, a nurse articulated that having complete information about the patients help a nurse to provide updates on the patient's health conditions for the doctor and relatives and elaborated:

> …I have a patient, [Patient's Name] ... She was pregnant…. I got to know that chest doctor…said that 'we must have her chest reviewed.' … I informed the doctor that 'how can we have chest X-ray; the patient is pregnant.' (SN-PR-5)

A thorough assessment that includes gathering all pertinent information about patients may aid nurses in identifying and prioritising the patient's needs. This is necessary for nurses to be able to provide patients with personalised care. The next theme will explore how to meet patient's needs.

5.2.3.3.2 Meeting patient needs

There are three components of this theme: provision of physical care, prompt care, and advocacy of the patients.

To provide effective care, it was found that a nurse must recognise and focus primarily on the physical needs of the patients. The first step is to conduct a thorough and personalised assessment. This may influence prioritising and addressing physical needs. Secondly, a nurse needs to provide care, ensuring it is evidence-based and satisfies the patient's fundamental needs in a timely manner. Following the patient assessment, nurses need to think critically about the information that has been generated and integrate their knowledge into practice to deliver whatever care is needed. A nurse described:

> First, I take history of the disease. What is happening with this disease? What is the reason for the loss of appetite. This might be due to allergy. Maybe he is vomiting because of the food. Maybe because of the bitter taste in drinking water… Then, I check what I have studied regarding that disease. According to books, what it is said about the medication, its good and adverse effects. How quickly would the patient recover? (SN-PU-8)

After understanding the patients' problems, nurses discussed their role in planning and implementing care by ensuring it is evidence-based. One of the nurses explained that evidence-based care is based on the clinical expertise of the professionals, respecting patient preferences, values, and beliefs, and integrating the best available evidence into practice. This kind of caring gesture may bring satisfaction and comfort to the patients. A nurse elaborated:

> Caring is a very broad term and evidence-based practice comes under caring. We can say that evidence-based practice is based on our knowledge, latest and whatever the updated evidence or literature says… So, when we talk about patients' preferences then we can say that the caring aspect is when the patient is comfortable and satisfied. (SN-PR-3)

Furthermore, patients and students emphasised that nurses need to pay attention to patient's physical care needs by helping them with the activities of daily living, such as providing hygiene care, changing incontinence pads, preventing bedsores, performing mouth care, serving meals, giving medication on time, making beds, and

accompanying them to the washroom. This behaviour may make patients feel happy and comfortable. For example, one of the student nurses illustrated:

> Yes. It is the basic quality that nurses can do to give good care to their patients… Good care means, giving body wash, giving medicines on time, mouth wash, preventing bedsores, stitches care, providing everything on time. If a nurse has all these qualities, then patients will be happy with that nurse and will always approach him/her. (ST-PU-3)

One of the patients shared the experience of the nurse helping with hygiene needs, *"When I came to the emergency department and was sent to the operation theatre, my body was dirty with soil. The two nurses came and cleaned my body. They shaved me; they made me neat and clean." (PA-PR-2)*

Similarly, a patient shared the experience of getting assistance to go to the washroom by the nurses:

> They deal very lovingly, very lovingly [repetition]. When I have to go to the washroom, they are ready to assist me. I don't like her to go to the washroom with female nurse, but she said, 'Uncle, I will take you to the washroom, it's okay, no problem.' At that level, they cooperate with us. Male nurses also do the same thing. I went to the washroom, and he cleaned me. He said, 'Call me when you finish, and I will clean you.' (PA-PR-6)

Another important part of the theme was the expectation of prompt care. Most of the patients expect prompt care by the nurses. A patient suggested that by resolving their issues promptly, they ensure that the patient is comfortable. A patient explained, *"They [patients] want their problems resolved. Whatever they require; it is easily provided to them. You know they don't have to ask for something again and again. They don't have to face the mental agony." (PA-PR 3)*

Nurses perform clinical reasoning skills to provide prompt care in a critical situation. One of the patients shared the experience of a prompt response by the nurse during an allergic reaction and said, *"This behaviour, is like when I had an allergy when receiving IV injection, she immediately gave an antidote injection and then informed the doctor." (PA-PU-16)*

One of the nurses reflected that the provision of prompt care can build a good caring relationship and clarified, *"If you [nurse] respond to them for every concern, I think, we build a good caring relationship with the patients." (SN-PU-7)*

When nurses have a busy schedule, they can overcome patient problems by delegating the tasks to the other team members. Nurses should support each other to provide good care to patients:

> I prefer whenever the patients call us [nurse], we should attend to them and help them. If you are busy, then you delegate your task to others... So, this is my value and I value responding to the patients on time and as a team. (SN-PR-3)

Due to a shortage of nurses in the public institution, nurses are unable to provide immediate care to the patients. A patient explained, *"If we compare with other hospitals [public], we can't see nurses. When we call them, they don't come. But here [private], when we call them, they are here in a second." (PA-PR-9)*

Prompt response to patient requests is an important aspect of providing effective care. However, nurses are often delayed in responding. As one of the student nurses shared:

> They [nurses] say, they'll do something in an hour and then it has been 2-3 hrs, things still don't happen. If they complain, you [nurse] open the door and say, 'Yes what happened to you' and you [nurse] listen and close the door and you [nurse] go away until the patient rings the bell 2-3 times and then you remember, yes, he [patient] rang the bell and asked for something to do. (ST-PR-1)

Finally, the theme focuses on advocating for the patients. Nurses appear to act as a link between the patient and the physician to fulfil and support the patient's best interests. Advocacy means speaking on behalf of the patients. For instance, a student nurse explained, *"Advocacy is to speak up or support a patient… I think it's important for the nurse to be an advocate for the patient when a person cannot take a stand for himself. Because patient nurse relationship is important." (ST-PR-5)*

Findings revealed that nurses need to be patient advocates. A student nurse stated that nurses are also entitled to receive respect and confidence similar to that given to physicians as she complained, *"A nurse should be given equal respect and confidence as that given to physicians, then a nurse can do patient's [advocacy]. But I haven't seen it." (ST-PR-6)*

As nurses have a close interaction with the patients, sometimes they are in a better position to help the doctors in deciding what is the best treatment for their patients. One of the nurses from the private hospital shared her experience:

> There was a patient with high blood pressure. He needed urgent IV intervention instead of oral intervention because the patient was suffering a hypertensive crisis… So uh, I informed his doctor that we should go for… hydralazine injection stat…and after getting confirmation from the doctor, we administered the IV medication and within 5 minutes the patient became stable… We should not only follow the doctor's order, but we should also suggest the best intervention for the patients… (SN-PR-3)

Nurses from public hospital were more involved in patient advocacy when patients were hesitant to talk to the doctors because of a language barrier, literacy or just being timid. Due to these hindrances, nurses intervened and communicated patient concerns to doctors. One of the nurses reported:

> Sometimes patients have concerns that they are unable to talk with the doctor. Sometimes doctors do not speak the local language of their patients as they come from a different cultural background. So, they [patients] try to explain but the doctors are unable to understand what they wanted to say. They ask us to explain that to their doctor: 'You talk to the doctor. We don't understand them.' In this case, we speak on patient's behalf. (SN-PU-7)

Nurses act as advocates for their patients and try to resolve their immediate needs by coordinating the healthcare team members. To be able to do this, nurses need to be respected so that they can convey patient problems to other members of the healthcare team. When a nurse cares for the patients well, the nurse often feels valued and appreciated. Being appreciated by patients and relatives is discussed as the next theme.

5.2.3.3.3 Being appreciated by patients and relatives

Patients and their relatives expressed gratitude to nurses who cared for them. A nurse from the public hospital was appreciated because she provided hygiene care for her patients. She explained:

> There was one patient who was paralysed and had back bedsore which was oozing with pus. I had just gotten off duty, but I arranged the necessary equipment and took the help of an assistant to give her a bed bath. Then I

> cleaned the wound with… and dressed it. I changed her clothes and bed sheet, combed her hair. Her sons told me, 'You are our sister.' (SN-PU-15)

Similarly, one of the nurses from the private hospital articulated a patient's appreciation in timely provision of treatment. The nurse explained:

> Sometimes it happens, when we give medication at 12:00 pm when we are supposed to give it at 10:00 am… patients have their complaints about these things. For me, I did 10 o'clock medication on time, gave feeding on time, and checked one hourly vital sign. When she was discharged, she said, 'he is the best nurse'. If the patient appreciates my work, then I feel that I have done my job. (SN-PR-4)

Nurses were appreciated by the patients and families for maintaining patient personal hygiene and administering medication on time. The ability to understand and address the needs of the patients through logical reasoning, and accurately undertaking nursing skills are key competencies of nursing. Competency in performing clinical procedures accurately is also the important role of the nurse. The following theme will reflect on this.

5.2.3.3.4 Competency in nursing skills

From the patients' perspectives, nurses were described as needing to be competent to perform clinical procedures to ensure comfort and prevent complications. Patients mentioned that nurses were particularly proficient at inserting cannulas into weak veins. A patient explained:

> They [nurses] have very good skills, I mean, it's a big deal to just pass a cannula… My veins are very thin, so it's impossible to pass the cannula. So, there was one nurse who was very good at it. So, I used to tell him that 'my cannula is about to get blocked'…So, he used to make sure before the shift ended to put a new cannula for me… (PA-PR-3)

One of the nurses verbalised a patient's expectations that intravenous cannulation would be successful at the first attempt. For example:

> So, I [Nurse] told him [patient] that 'We are planning for your liver transplant, and we need to draw a blood sample.' He said, 'Ok madam but you have to take it in one prick only and to do it yourself.'… So, I agreed. (SN-PR-5)

Patients in both public and private hospitals expressed their desire to be cannulated by a trained professional. By this, patients expressed a high value and confidence with a skilled nurse. A nurse's competence is recognised as an important aspect of caring. The subsequent section will explore the importance of meeting the spiritual needs that may help patients to cope with illness, resulting in physical and emotional well-being.

5.2.3.4 Consideration of spiritual needs

The practise of caring behaviour was described as considering and facilitating the patient's spiritual practices. Meeting the patient's spiritual needs may help to cope with illness, promote mental well-being, and regain their faith. In an Islamic setting, faith is an intrinsic part of spiritual needs. This concept is derived from two themes: assessing and facilitating spiritual practices and encouraging patients to have hope.

5.2.3.4.1 Assessing and facilitating spiritual practices

Assessment of spiritual needs is also very important. The nurses from both public and private hospitals include spiritual assessments and help patients by providing them with resources, such as prayer mats and the holy book for religious practices. One of the nurses articulated:

> We fill out the initial assessment form and we ask the patient about their spiritual needs… If a patient is anxious and fearful, we suggest using spiritual activities, to make them feel calm and relaxed… In our hospital, we ensure that every cupboard contains the Holy book and a prayer mat… (SN-PR-4)

The student nurse perceived that they needed to assess the spiritual distress of the patients. If the patient is spiritually distressed, he or she may not cooperate with the nurse. A nurse affirmed:

> When a person loses hope in God and breaks his relationship with Him and thinks nothing would happen, it means that he is spiritually distressed. When he loses his hope and faith in God, he will not cooperate with you…We need to ask, 'Do you want to pray?' if he is not ready to listen to the holy verses of Qur'an or the Bible, this kind of patient, we think, is probably in spiritual distress. (ST-PU-2)

The next section will explore differences of spiritual care in public and private hospitals. For instance, nurses from the public hospital offered prayers and play audiotape recording 'Surah Rehman' for the provision of spiritual care. A nurse and student nurse shared their experiences, *"Let's suppose a patient is a Muslim and he or she is anxious about the disease, we recite the Surahs for them." (SN-PU-13); "… like play a*

recording of 'Surah Rehman', this comes under the spiritual care for patients' healing." (ST-PU-6)

Whereas nurses in the private hospital tend to call spiritual leaders to pray for the patients. They pray and counsel the patients, as illustrated by a student nurse:

> People belong to different religions, right. So, first of all, you need to know what their religious beliefs are. Then according to their belief, you have to provide them with facilities. Usually, as you must have observed in [name of private hospital] that there a spiritual leader who comes weekly to do counselling and reciting prayers... (ST-PU-4)

The above quotes demonstrate the importance of conducting spiritual assessment to determine a patient's needs. This enables nurses to assist and encourage patients to use the resources to carry out their religious rituals and thus improve their spiritual well-being.

While some participants consider the importance of assessing and providing spiritual care, some do not. Most of the patients think that everyone has their own values and beliefs regarding spirituality, which is neither explored by nurses nor demanded by patients. However, a patient from the private hospital felt that nurses do not provide spiritual care because of the workload in the ward. In addition, they felt nurses should be responsible for the provision of the best medical services for the recovery of their health and do not consider providing spiritual care as important.

> I am not here to get spiritual support…I am here to get medical treatment. For spiritual support, I would say, I have to go to the mosque. I have to give some charity. They [nurses] should be responsible for medication, the best medical services, and on-time delivery of all these medical services. (PA-PR-4)

"They do their specific nursing related tasks and might be they don't have time to provide spiritual care. She is not only taking care of me, but also care of other patients too." (PA-PR-9)

The nurses perceived that due to differences of beliefs, it is difficult for the nurses to provide spiritual care. Furthermore, a student nurse said that it is also important to have a strong belief in God. She exclaimed:

> I guess it should be provided but the thing is if I am a Christian how I can provide spiritual care to a Muslim. If a nurse is from the same religion, then she can provide care, if not, then how can she do that. (ST-PR-6)

The findings revealed various reasons for nurses for not providing patients with spiritual needs. These include not having the time to provide spiritual care, patients not believing that spiritual care is part of the nurse's role and differences in spirituality between the nurse and the patient, and lack of a strong belief in God. Instilling hope in patients is an important aspect of caring behaviour and it may enhance spiritual well-being. The following theme will explore this aspect further.

5.2.3.4.2 Encouraging patients to have hope

Participants from all three groups said that nurses should support patients to have hope by encouraging them to remember Allah because healing is in His hands. The building of trusting relationships may help nurses to instil hope in patients. As one of the patients stressed:

> They should encourage us. So, we get better and are discharged early… If we lose hope about our disease then they should say, 'Nothing will happen. There are many people, who have the same problem, do not lose hope.' (PA-PU-12)

"First of all, if you want to give patients hope, then you must build trust. If you do not build trust in your patients, then you can't give them hope…" (SN-PU-10)

To encourage spiritual well-being in patients, the nurse should explore the positive experiences of the patients. One of the student nurses stated:

> ...When I talk to the patient, I explore the positive points in their life, for example, 'Do you have children? Are they educated? Do you have a wife.' I explore about his job and family members; I try to find out this then it's very easy to give hope. 'You have the blessings of God, you have children, many people don't have children, you have your wife, you are living in a good environment, you have your own house, if He has put you in difficulty, you got upset, don't do this. You can come out of this difficulty; you should be an example for your children.' (ST-PU-2)

Maintaining and fostering hope in the patient is important, and in Pakistan hope usually means faith in God. This is important for a patient's sense of well-being and speedy recovery. Culturally sensitive care is an essential aspect of providing patient-centered care. Nurses need to be sensitive and respect patients' cultural needs, values, and beliefs and this is the next theme.

5.2.3.5 Culturally sensitive care

The concept of providing culturally sensitive care emerged from the data. The findings revealed that many patients and nurses were from different ethnic groups in the hospital settings; however, nurses appeared to give importance to patient's cultural values and beliefs even when they were different from their own. The participants felt that it is important to give cultural care because it helps patients feel at ease in the hospital setting. In this concept there was only one theme, respecting patient values and beliefs, which is discussed below.

5.2.3.5.1 Respecting patient values and beliefs

This theme encompassed the importance of providing cultural care for the patients. The data obtained from the nurses showed that some patients strictly follow their cultural practices, and the nurses allow those practices if they are safe for them, such as tying thread around wrist and neck, use of holy water and honey. Maintaining the privacy is of a great significance to patients and before any procedure, nurses ensure privacy. In the Pakistani culture, most patients prefer care to be given by a nurse of the same gender. A nurse should be able to recognise cultural preferences and behave accordingly. A nurse shared her experience and elaborated:

> In Pakistani culture, most of the female patients are comfortable only with female nurses. They do not want male nurses to take care of them. Similarly, many men prefer male nurses to do any procedure or take care of them. To overcome this issue, nurses are assigned according to their gender preference. If they can't provide a female nurse, then they explain to the patient about it. (SN-PR-3)

Before performing any procedure, nurses assure patients to make sure that they are relaxed and cooperative. For instance, a nurse said:

> For example, if we have to insert foleys catheter, mostly they [female patients] cover themselves. We guide them, "no man will observe you, only me and you. We take care of your privacy… 'Don't get tense, no one will see you.' We make them feel at ease, so that they feel relaxed and comfortably allow us to do the procedure. (SN-PU-9)

Furthermore, nurses should ask patients how they would like to be addressed by the nurse. The patients from both public and private hospitals felt that a nurse should not address them by their name which helps to develop good relationship between the nurse and patients. For instance, one of the patients and a nurse commented:

> If you call out the name of the older patient, you should call them sir or use respectful words, for example, Baji or Aunty. In our culture, it seems quite disrespectful when you call the patient by his or her name. (PA-PR-7)

"In this way, we [nurses] are developing relationship with the patient…They [patients] share their problem with us…" (SN-PU-8)

However, while some of the participants considered the provision of cultural care to be important, some others, similar to the discussion on spiritual care, were more concerned about the timely provision of medical treatment rather than cultural care.

> Not at all, not at all, actually, in the hospital, every patient should get timely medical treatment. We are here for the medication. The nurse should be responsible for the medication. The healthcare services hospital is not for implementing cultural practices. (PA-PR-4)

Furthermore, a cultural need assessment of the patients did not appear to be performed by the nurses from the public hospital. One of the nurses stated, *"Truly speaking, we don't take care of the cultural values and beliefs of the patients." (SN-PU-10)*

The above quotes exemplify the importance of a nurse assessing and knowing a patient's values, beliefs, attitudes, preferences, and practices. However, some patients considered the provision of medical care to be more important than cultural care. The next section will explore the importance of the nurse demonstrating a therapeutic interpersonal relationship with patients. This may help nurses to understand the patient experience, which is central to effective patient care.

5.2.3.6 Interpersonal relationships

The concept of interpersonal relationship is supported by two themes: building a trusting relationship and therapeutic communication skills. This concept encompasses how nurses connect with patients, by establishing a positive rapport, which may result in establishing a trusting relationship.

5.2.3.6.1 Building a trusting relationship

Developing a trusting relationship between nurses and patients by maintaining confidentiality was thought to be an important aspect of caring. In addition, nurses introducing themselves to the patients can also help in developing a trusting relationship. For instance, nurses from the public sector said:

> Sometimes they [patient] do not want to disclose their disease to others and keep it within their family then it is our duty to keep that information confidential. If they trust you, and share information with you, then you shouldn't leak that out. (SN-PU-10)

"You have to introduce yourself, this way, trust will be built between you and the patient." …They can trust you. They can talk to you. He [patient] is not afraid to talk about their needs…" (SN-PU-7)

Nurses believed that they have a responsibility to create a trusting environment by valuing patient privacy. Furthermore, giving a professional introduction is also crucial for a positive relationship. This may help the patients feel more at ease when speaking with nurses. In health care, effective communication is critical for the nurse patient relationship. Nurses can make patients feel that their concerns are being acknowledged. This may help them to alleviate concerns and allow nurses to gain relevant information from the patients. The next section will explore the importance of therapeutic communication skills while engaging with patients.

5.2.3.6.2 Therapeutic communication skill

The findings of the participants from all three groups showed that nurses practise effective communication by applying therapeutic communication skills, more specifically, greeting and introducing themselves to the patients, spending time with them, and listening to their concerns. Nonverbal gestures, such as smiling and maintaining eye contact are also highlighted. Most of the participants suggested that nurses need to be polite and softly spoken even if patients or their families behave rudely. More importantly, a nurse develops listening skills and the appropriate choice of words to use while interacting with the patients. For example, *"So uh, in communication skills, verbal and nonverbal and in verbal, we also uh think about nurses listening skills uh the choice of words makes the communication therapeutic and professional." (SN-PR-3)*

Some patients are distressed because of their health conditions and their psychological needs can be addressed by actively listening to their concerns. A nurse narrated:

> Because of disease they [patients] are irritable. Sometimes, patients are very irritable and when we talk to them, they talk very rudely. It means they are mentally disturbed. So, talk to them. There is a term we learned; therapeutic relationship. If he wants to talk to us, then we spend two minutes listening to them. So, in this way, their psychological needs are fulfilled. (SN-PU-7)

If a nurse listens to a patient's concerns, it may help them to relax. Nurses can also get additional information about the patients enabling treatment plans to be developed. One of the student nurses explained, *"…When you listen to them then they feel someone is listening. They get relaxed. We should get complete information about the patient. Through this, one can decide on their treatment and also provide benefits to them." (ST-PU-6)*

In another example, a patient after being discharged from the hospital, remembered the nurse and appreciated the care provided by her. She provided emotional support by listening, encouraging, and reassuring the patient. A nurse explained:

> I had a patient with an irregular cardiac rhythm issue, and she went for cardiac bypass surgery…I was with the patient for almost one month. At that time, she was facing a family issue. As a health care worker, I had to understand what was going through the patient when he was struggling with life and death and there was no emotional support from the family and at that moment, I had to be with the patient encouraging and reassuring her. After two months, I met a patient in the clinic. She called me and she said, 'Do you recognise me?' I was unable to recognise her. She was thankful to me and prayed for me. 'You provided a lot of physical and emotional support. You people did a great job.' (SN-PU-11)

It was thought that nurses should maintain a professional attitude and not let any personal issues affect patient care. As one of the student nurses explained:

> Whatever the personal problems nurses have, it shouldn't influence their patient care. We should be positive and understand the patients. Whatever they complain, we should listen to them attentively. This resolves half of their problems. Listening to patient's concern is very important… Patients know about themselves. First of all, I listen to them [patients]. What they want to discuss then I present solutions to their concerns. (ST-PU-5)

Participants from all three groups emphasised a thought-provoking aspect of interpersonal relationship in which a nurse should not react to the irritating behaviour of patients and family members because it creates a negative image of caring. The following quote from a student nurse and a patient exemplified this:

> In my opinion, tolerance level has to be very high. I mean the kind of tolerance level that he [nurse] won't react to any kind of bad behaviour of any person he is dealing with. Whether patients or their relatives…If you don't have tolerance then it will be difficult for you to show care. If you don't take things positively then you will always be trapped in issues and problems. (ST-PU-3)

The patients expect nurses to show caring attitude by putting a smile on their face while interacting with them. This is what a nurse explained:

> One thing I disliked was when I asked one of the nurses about my surgery. She replied, 'I don't know, you better ask the doctor.' Her facial expression was irritating. You [nurse] should have a smiling face. If your face reflects that you are upset or angry, it depresses the patient… (PA-PR-7)

A good relationship can be built by a nurse introducing themselves and greeting the patient. This can help the patients feel comfortable with the nurses. One of the nurses said, *"I will say that they [nurses] should first introduce themselves. So, a good relationship builds up. They can trust you. They can talk to you. He [patient] isn't afraid of you when he talks about his needs…" (SN-PU-7)*

A nurse also encourages patients to share their concerns. One of the nurses expressed:

> So, sometimes, patients are very much vocal, they can explain their issue, but some patients are shy, and they are not encouraged to share their concerns with nurses or doctors. So, we should identify this kind of shyness…, so that patients are also encouraged to share their concerns. (SN-PR-3)

The findings indicate that nurses can perform non-pharmaceutical interventions such as providing therapeutic touch while communicating with patients. This may be the important behaviour for building an effective relationship and may help patients be less anxious. A nurse explained:

> When you talk to them [patients], hold their hands, through touch, the reflexes travel, and they have a feeling of love and relief of anxiety. Someone asked Hakim Lukman [practitioner of traditional medicine] 'if people are sick, how can we treat them, what we should do?' He said, … firstly, you care for them, or you can give a gift, the words of love, as we give to our family…When you provide proper care, like bedding, positioning, providing medication, this all comes under the care and when we use kind words, it is a gift for the patients. (SN-PU-15)

Another nurse from the public hospital also perceived the importance of therapeutic touch; however, felt that it is not often practised:

> Our nurses' problem is that we don't touch our patients. They [nurses] may feel that if they touch the patient, they may get the disease. Or most of the time when we go to the patients, we stand and talk from a distance. Now you tell me …what he feels. We should stand by them and talk. If you touch even a little bit, so they feel, we are treating them well. So, they feel good. Talk to them nicely; speak kindly with a smiling face. A smile can cure disease and many issues can be solved. (SN-PU10)

Therapeutic communication skills such as listening to patient concerns, being humble and respectful are considered to be caring behaviour. The participants recognised the importance of effective patient communication. A nurse needs to inform the patients about their health conditions and treatment plan with the aim of reducing their anxiety and worries. As mentioned in the theme, 'protecting patients from harm,' patients experience psychological distress because of a lack of information about their condition and treatment plan. Hence, there is a role for nurses in educating patients about their conditions and treatment options. The following section will explore the participants' perceptions of caring behaviour within the context of their role in supporting and educating patients.

5.2.3.7 Role in supporting and educating patients

Participants also described caring as providing information for patients about their health conditions, treatment plans, and any other pertinent information. Patients may benefit from receiving information to help them mentally prepare for their treatment and minimise their worries. The role in supporting and educating patients was associated with four themes: meeting patient expectations, characteristics of a nurse, providing reassurance to patients, and barrier to educating patients.

5.2.3.7.1 Meeting patient expectations

Most of the participants across all groups highlighted the need for nurses to educate their patients about their condition and treatment plan. Patients wanted to be informed about their condition as one highlighted:

> If we ask more than once, we act like a child and the child may ask fifty times. They [nurses] speak so fast like a waiter at hotels, say fifty things at once. So how can we understand and they [nurses] say, 'We told you', yes, they told us, but she should ensure that what she informs us is communicated or not, whether we have understood or not? (PA-PU-14)

While administering medication, the patient is expected to be educated on what they had been prescribed. Before giving it to them, the nurses need to explain the action or effects of medication. One of the patients expressed, *"…They should explain which medication is for pain, or temperature. 4-5 medications they bring and tell us to ingest. They should explain that medication helps me in relieving pain or healing my wound." (PA-PR-2)*

The patient shared the experience that they appreciated when nurses used simple language:

> Like minor things, when they remove bag [urinary bag], they say, 'You have to drink water.' When they are removing the catheter, they say, 'You have to take a deep breath.' 'If you are getting irritation then you have to drink water.' Like in this way, in a simple language, they guide us. (PA-PR-9)

Patients felt happy if nurses informed them about their health conditions. However, one of the nurses highlighted, nurses, especially female nurses do not educate the patients. One exemplar quote highlighted:

> … Yesterday, one patient came to me, he was asking about the lab report. I explained to him in detail. He said, 'We come to you because you listen to us, while other nurses don't.' He did not know that I am a nurse. His thinking was that only females are nurses. He did not have the awareness that males are also nurses. He said, 'Nurses do not tell us.' I told him that I am also a nurse. (SN-PU-14)

The above extracts express that patients felt comfortable when they were informed about their health condition. It is the responsibility of the nurse to have effective communication skills to ensure they use simple language when educating patients. To do this effectively, a nurse requires certain skills or traits. This will be discussed in the next section.

5.2.3.7.2 Characteristics of a nurse

Participants identified several qualities of the nurse which contributed to better patient support. First, a nurse needs to have sufficient information about the patient's health condition. Second, a nurse should be a good listener to understand the patient's problems and educate them accordingly. Third, nurses should be confident in their abilities to educate patients. Finally, the nurse should provide up to date knowledge for patients. For instance, nurses and a student nurse expressed:

> In my opinion, whenever you come for duty, you must know everything about the patients in detail. See if your knowledge is strong, only then you will be able to make someone else strong. And if I am talking to the patients and giving half the information, making them confused then how will the patients be satisfied. That's why a nurse should first read the patient's file accurately, try to take all the necessary information and then educate them. Then she [nurse] would be able to satisfy the patients, otherwise never. (SN-PR-5)

If nurses are confident, then patients will listen to them. A student nurse said:

> I have seen most of the nurses; they counsel the patient very well. Most of them are confident and whatever they say, they say it with a lot of confidence. When they say in such a way, the patient listens to them more carefully… (ST-PR-1)

Nurses appeared to use several skills and experiences when communicating with patients. A nurse explained treatment options and shared her experience of caring for patients with the same condition. It appeared to make patients feel satisfied and reduce their fear. The nurse confidently explained:

> We educate our patients based on our communication skills [put finger on forehead], based on our knowledge, based on our experience…we teach them about different options, this is the advantage of the treatment; this is the disadvantage of the treatment…we encourage patients to ask questions as well…So, these patients make their own decision based on that discussion… (SN-PR-3)

The above extracts highlight the importance of certain skills a nurse should have when educating patients. This may help patients better understand their health conditions and support them to make informed decisions. Furthermore, delivering education to patients through various ways can help to resolve their queries and reduce their anxiety and worries. The following section will explore this theme.

5.2.3.7.3 Providing reassurance to patients

The patients described that nurses acknowledged their concerns and reduced their fears about their illness. Nurses use different teaching strategies, including pamphlets and videos to teach patients about their health condition. One of the patients shared the experience of nurse reassuring the patient about the operation:

> I liked it the most, when a nurse, before surgery, came to me and gave me a pamphlet, and explained to me how the surgery would be done. She taught me what would happen during surgery and what would happen after surgery. She answered my questions about my surgery… So, she explained to me and said, 'You have a stone in your gallbladder, and it needs to be removed…If this stone will go into other ducts, then they will get obstructed.' She discussed the complications as well. So, she counselled me; this was very effective and then I decided that yes, I should go for surgery. (PA-PR-7)

Another patient expressed the importance of being educated as it relieves patient worries *"… when she [nurse] tells the patients minor things, so their [patients] worries are over. When a nurse provides information, their [patients] half of the worries are over." (PA-PU-15)*

One of the student nurses shared the experience of educating the patients that brought a positive outcome:

> Yes, I had a patient with chest pain… her ECG was ok. But she was under stress. I told her that female cardiac issues could be genetic. After this conversation, she was relaxed and said, 'Now, I am feeling better'. When she came, her BP was 130/90 and when she left after half an hour, it was 120/80. She was relaxed after our conversation. (ST-PU-6)

The use of different teaching strategies to explain and educate patients about their health condition may reduce fear and bring positive changes. However, nurses

sometimes experience barriers to educating patients. This will be further explored in the next theme.

5.2.3.7.4 Barrier to educating patients

In the discussion above, it was found that educating patients is very important to help them mentally prepare for their treatment plan and minimise their fears, concerns, and worries. However, a student and a patient described that nurses often do not always take patient education seriously. For instance, one of the student nurses said, *"I have seen quite many doctors, who educate the patients…But when it comes to nurses; I think a few nurses talk about the medication, they focus on diet only…" (St-PR-5)*

The nurses appear to be restricted by time for educating patients. One of the patients complained:

> Sometimes we have so many medications. There are different times of medications. So, they [nurses] should write down and give it to us and write it down in a way that we understand. We are educated and understand. For those who are illiterates then it is difficult for them to understand. But they do little teaching. Educating the patient takes time. She might save time, or she does not have time… Neither do the doctors tell us about our illness or about the treatments that are there? (PA-PU-14)

The necessity of educating patients to help them learn and understand their treatment and health condition has been discussed in this section. Patients may be empowered by education and be able to participate in their care, which may result in a better outcome for their health. The following section will explore issues further within the context of supporting patients to be independent.

5.2.3.8 Supporting patients to be independent

The nurses appeared to be able to support patients in becoming independent in their care by assessing their needs, teaching, encouraging, and motivating them. These behaviours help the patients to take ownership of their health, identify their capability, and prepare for self-management. This concept is derived from three themes: assessing patient needs, empowering patients to self-care and supporting patient decisions.

5.2.3.8.1 Assessing patient needs

Nurses assessing patients need and implementing an individualised approach emerged as being important. Depending on the level of assistance and through personal needs assessment and reassessment nurses can set goals with patients. One of the nurses identified a good nurse as one who assesses needs, but does not do everything for the patient, placing some emphasis on promoting independence. This is illustrated in this quotation:

> Nurses assess their [patients] assistance level on daily basis and every shift [repetition] on every visit and they prepare the patient to become independent as well. Uh, after assessing, they assist the patient in setting the goal to make them independent. For example, if the patient has to go to the washroom, a good nurse should not assist the patient, but should encourage the patients to help themselves… the patient should get up himself, but when he cannot then the nurse should give assistance to the patient and if the patient is not able to get up with little assistance, the nurse gives full assistance… (SN-PR-3)

Likewise, one of the students shared the experience of making a patient independent in self-care while giving a bed bath:

> When I was giving bed bath to the patient, I gave partial bed bath. I observed that he can do self-care. So, I gave him a bath sponge and told the patient to clean his hands, legs and the perineal area… (ST-PR-2)

The findings illustrate that in doing need assessments, the nurse and the patient can set goals to help patients with self-care and take control of their health and becoming self-sufficient. This perspective will be discussed in the next theme.

5.2.3.8.2 Empowering patients to self-care

After assessing the needs of the patients, the next step that nurses perform, in educating patients is enabling them to be responsible for their health and to gain greater control over making informed decisions and actions. The nurse's role appears to be helping patients prepare physically and mentally, as well as encouraging them to acquire self-efficacy. When the patients engage in self-care activities the nurses monitor them. To involve the patients in their care, a trusting relationship needs to be developed, so that patients may follow the nurse’s instructions. One of the nurses reflected:

> So, for involving the patients, we should have a good rapport with the patients and if the patient is trusting in a nurse, then the patient will also follow the nurse's instructions. The nurses give instructions to the patients that 'you should stand up, you should go to the washroom independently, you should eat well, you should walk daily, and you should change your dress.' So, if such instructions are given to the patients, they will respond to only that nurse effectively, when the patients trust the nurses and respect them. Uh [micro pause] uh… patients will respond to those nurses with whom they have developed a good rapport. (SN-PR-3)

Another nurse shared the experience of encouraging the patients to become independent so any mishap can be managed on time and the patients should be in a better condition at the time of discharge:

> We have caesarean patients. We need to mobilise them as soon as we receive the orders… Most of the time, patients are reluctant to do that and refuse by saying, 'It is very painful, we cannot.' I try to counsel them by saying that 'Look you are in hospital premises, we are here, and God forbid if something happens to you, we are here to take care of you. If the same thing you will try at home, there will be no one to guide or support you. You will face difficulty there… better to give yourself a trial here and go home in a better condition.' It is very important to take them into confidence, in this way they listen to us and agree. (SN-PR-5)

The nurses from the private hospital considered building rapport with the patients to be important so that they follow their nurse's instructions. They also want to make the patients self-sufficient before they are discharged. However, nurses from the public hospital tend to provide support only through verbal instructions of performing activities of daily living. One of the nurses shared the experience:

> We educate them; 'Try not to be dependent on others.' …Most of the time patients are stable in CCU (Coronary Care Unit). So, I encourage them to do physiotherapy by themselves. 'You have to do hand movement, you have to do leg movement, and you have to do deep breathing exercise.' …So, we should educate them and alleviate their fears and worries. (SN-PU-11)

A nurse shared the experience of encouraging and motivating the patients to become independent and getting a positive outcome:

> We had a COVID patient, and he stayed for 10 days on a ventilator and he had second-degree bedsore when we helped him to sit on the bed he was trembling. We told him, 'You will not be stable, unless you move.' We positioned him. He didn't want to sit down. We compelled him to sit. He didn't want to walk. But we compelled him to walk. Gradually, he started to walk by himself, and his skin was intact. (SN-PR-4)

One of the nurses emphasised enhancing self-efficacy to make patients independent. She narrated, *"We should make the patients independent by enhancing their self-efficacy, motivation, and enhancing their confidence. So, if a patient is knowledgeable and if a patient is motivated and confident, a patient will indulge in self-care behaviour."* A nurse viewed self-efficacy as an individual's belief in their own ability to complete a task, *"Self-efficacy is when the patients are well-motivated and do their tasks… So, before making the patients walk, we should make them mentally prepared that they can walk. We should give patients confidence that they can do everything…" (SN-PR-3)*

One of the student nurses reflected that some nurses do not help patients to become independent in their care:

> That basically, [rubbing nose by left finger] you are not asking the patients to exercise their autonomy. The amount of autonomy is very limited. We do not even ask them [patients] to take their meals and feed themselves. You can say, 'This is your meal,' make them sit in an appropriate position and say, 'You can sit upright for half an hour.' In this way, you are allowing the patients to decide for themselves. This helps the patients to keep a sense of control. They have some control over their body. (ST-PR-1)

This theme showed a variety of approaches to support patients, including educating, encouraging, and motivating them to practise self-management. As a result, their health improves leading to positive outcomes. If they are informed about their conditions, it may be easier for them to make informed decisions and stick to the treatment plan. This will be discussed more in the following section.

5.2.3.8.3 Supporting patient decision

Some nurses talked about how they help the patients understand why procedures must be done. Some nurses shared their experiences:

> Sometimes, the cannula is not working. We [nurses] say, 'It's not working, it needs to be changed.' They [patients] say, 'It's going. So, let it go.' 'No, it is not working you will get cellulitis, see the redness.' If we explain it to them and then change it [cannula] they are satisfied… (SN-PU-10)

One of the patients shared the experience of getting support from a nurse to make a decision on pain killer medication:

> Yeah, in case of painkiller, they did ask me whether I have to take option A or option B. There was [name of medication] and [name of medication]. So, I have to decide based on my pain. If there wasn't too much pain, I can take [name of medication]. Because I know painkillers are not good for you unless it's important. Yeah, so, if I don't really need them, I just skip them. (PA-PR-3)

One of the patients shared the experience of taking decision on selecting the vein for IV cannulation: *"When they [nurses] wanted to take blood, first they asked me, 'I have to take blood, which vein can I draw the blood from? When I direct them, they took blood from it." (PA-PU-11)*

The above theme illustrates how patients came to the decision about a small task. It was evident that the nurses were taught the concept of respecting autonomy, but it did not play out in practice. In Pakistan, family members are usually responsible for making decisions on behalf of the relative who is in hospital. This is exemplified by an excerpt from a student nurse:

> We have been taught that the patients have the right to make decisions, any sort of decision…They are the decision makers. You can give them an option. It is up to the patient to go ahead to pick what they feel the best… But here in Pakistan, in our culture, I have seen that it is not the patients who make the decision, but their family members. You are not getting consent from the patient; you are getting consent from the family members. Nobody asks the patients…in the Western countries there is always the patient who has the right. If you do not ask the patient, the patient can sue you. It is a very different system here. (ST-PR-1)

Nurses appear to support the patients in making the best health decisions possible. This may have a positive impact on their health. The findings from this section indicate that if nurses have a role in educating patients, this enables them to become more empowered, take control of their own health, and assists them in making informed decisions about their care. The nurse has a key role in promoting independence in all routine activities, while offering appropriate assistance as necessary. Nursing showing caring behaviour was reported by the majority of participants. However, a few of them discussed nurses' unethical behaviour. This will be discussed in the next section.

5.2.3.9 Unethical behaviour of nurses

The concept of unethical behaviour of nurses emerged from the data and described some unacceptable or nonprofessional behaviour such as being disrespectful towards patients, which may affect nurse-patient relationship, incompetence and lack of accountability. This concept is supported by three themes: communication skills; practical procedures; and provision of information.

5.2.3.9.1 Communication skills

The nurse participants discussed how the nurses spoke to patients and relatives, which influenced their relationship with them. For example, a nurse showing poor communication skills is highlighted:

> If they [attendants (patient's relatives)] ask anything, they [nurses] unnecessarily scold the patient's attendants. Because they [attendants] do not know about the patient's disease, they expect the details from the nurses. But they scold them and shut them down. The attendants are afraid to talk to the nurses. (SN-PU-14)

Patients complained about the ineffective communication skills of the nurses such as not welcoming the patients. For instance, one of the students shared the experience:

> I went to the patient's room…he [patient] said 'I am here since yesterday and none of you showed the etiquette when entering the room, talking, greeting, and dealing with the patients. Nurses give orders that we have to do this, and do that, no greeting, no introduction of themselves and no courteous behaviour at all…' (ST-PU-4)

During the nurse-patient interaction, a nurse's casual and unacceptable behaviours can hinder establishing nurse-patient relationship. The next theme will explore how patients experiences of nurses poorly performing a procedure can result in harm.

5.2.3.9.2 Practical procedures

This theme encompassed nurses not being competent especially in IV cannula administration and taking blood which might lead to discomfort or pain. To avoid injury, a patient participant believed that medical procedures should be performed by experts. Furthermore, the nurses also delay in completing practical procedures. As one of the patients shared the experience:

> It was a bad experience. They [nurses] were unable to withdraw blood and the vein was burst and there were bruises in that area. This procedure should be done by an expert. They should have practiced it…I know while drawing the blood, they should not puncture the vein. But she [nurse] was puncturing the vein. I told her, 'Do not do this again. If you do not know, you should ask for help.' Pain threshold differs among patients. Already, they are under stress. She must be careful. (PA-PR-9)

Another patient experienced a delay in completing the procedure said:

> When we said, 'Drip is finished.' They said, 'You close it.' Then my parents requested the nearby attendant. She came and removed the drip. The nurse in the evening, when we called her, she did not come at that time. Later, she came and aggressively asked us, 'What is the problem with you.' When we said, 'Drip is not going,' she said, 'Stop it, we will check it.' After finishing the tasks of all the patients, she came at midnight and passed the cannula. (PA-PU-12).

The above quotes suggest that nurses need to adhere to ethical conduct, so the patient care is not jeopardised. However, some nurses failed to meet those standards and fulfil their responsibilities. An incompetent nurse displays unethical conduct by putting the patients at risk. The next theme will focus on the patients' frustration with the nurses, who failed to provide detailed information regarding medical or surgical treatments.

5.2.3.9.3 Provision of information

The findings reveal that nurses do not always provide adequate information for the patients about their treatment plan. For instance, one of the students shared, *"The common complaints that I heard from patients is that they often do not know when a procedure is to be done, their treatment plan, and time of implementation…" (ST-PR-1)*

In addition, patients are unaware of a nurse's scope of responsibilities. Because of this lack of knowledge, they are afraid to ask a nurse something that is not within her or his responsibility. For instance, one of the patients said:

> We should know what tasks she can perform. So, we can ask for it. I am afraid that I ask her for something that she is not responsible for and would hurt her or get her irritated. So, a person may be afraid of asking for anything. (PA-PU-14)

The findings indicated that patients expect two types of information. Firstly, information related to their treatment plan and health condition, and secondly information about the scope of nurse's responsibilities so they know what they can ask nurses to do. The major role of a nurse is to fulfil their task properly by providing support to patients during their illness including addressing their physical needs. However, this aspect of care can be overlooked by a nurse. The next section will explore different challenges faced by nurses in demonstrating caring behaviour.

5.2.3.10 Challenges to caring behaviour

This concept consists of participants' experiences of challenges nurses face in demonstrating caring behaviour. Those challenges are divided into six themes: nurses workload; lack of appreciation from senior nurses; use of technology; behaviour of patients and relatives; nurses personal issues, and reciprocity.

5.2.3.10.1 Nurses workload

Student nurses commented that because of the low ratio of nurses to patients, the nurse's workload increases. Because of this, nurses may become irritable or disrespectful to patients. Other examples were that sometimes patient's concerns were not resolved and nurses were unable to follow infection protocol guidelines. As student nurses pointed out:

> … I (long pause) I would say that every nurse should show a caring attitude because it is the obligation of our profession…if unfortunately, someone is not showing caring behaviour then the reason must be the burden or workload in government hospitals, as when one nurse has to look after 50 patients…If she [nurse] has to give an injection to the patient, it takes two to four hours to attend to all patients. (ST-PU-1).

"*…but at times because of so many patients, you do not have enough time to change the gloves between patients and you have to manage things without taking much care about infection control." (ST-PU-3)*

The findings also indicated that nurses were involved in completing documentation which affects patient care. As one of the nurses stated, *"Many patients are admitted at [hospital name] …They [nurses] have to write patients' notes. They are busy with computers… we [nurses] have to document everything…" (SN-PR-3)*.

Nurses spend time completing documentation for the continuity of care and self-protection and legal accountability. These activities may hinder giving care to patients. Nurses realise the importance of providing quality care. However, due to the increased workload, it is not always possible to listen to the patients and provide comfort. A patient participant suggested that this could be resolved by implementing different strategies, such as increasing the number of nurses in the ward to care for the patients or doctors taking on some of the nursing duties:

> Only two people are here. If they [hospital administration] increase the number of nurses, it would be great. Sometimes, patients need cleaning. So, at least two nurses should take care of them. God forbid, if something happens to the patient, so the other nurse can handle it. (PA-PR-2)

"…A few tasks can be done by the doctors. If the doctor is taking history of the patient, they can check vital signs. They call the nurse to check the vital signs." (SN-PU-15)

A nurse participant expressed guilt for not fulfilling her responsibilities. Because of the workload, they often get help from the patient's relatives to perform routine tasks:

> Sometimes, I feel sorry that I am not fulfilling my duties because of my workload. We instruct the attendant [patient's relative] about care like NG feeding. If we have 35 patients, most of the patients are on NG feeding. I am unable to feed all of them, but I instruct them [attendant] and they follow my instructions… (SN-PU-7)

Workload management is a significant aspect to improve patient care. There are different strategies highlighted by the nurses and patients such as encouraging family members to participate in patient care. Having enough nurses in the ward is imperative to avoid jeopardising the safety of the patients and to treat them promptly. The doctors can contribute to caretaking by sharing some responsibilities with nurses. Recognition and motivation by senior nurses to their juniors is also important to improve the care by nurses. However, this is not always done.

5.2.3.10.2 Lack of appreciation from senior nurses

The findings revealed that nurses need appreciation for their hard work. Sometimes, nurses are not given their due credit and appreciation by senior staff. For example, one of the nurses reflected, *"…we are not getting appreciation from senior nurses. No matter how good your work is, you are demotivated when you do any mistake." (SN-PR-4)*

An appreciation in any form boosts morale and motivates nurses to perform better. Demotivation may be one of the major hurdles in demonstrating caring behaviour. Caring behaviour is also affected by today's technology. While technology may improve patient care; however, it may also hinder caring behaviour.

5.2.3.10.3 Use of technology

Because of technology, some participants felt that nurses focus on machines rather than on patients. As one of the nurses explained:

> …They [nurses] are busy with technology [repetition], such as ventilator, IABP monitor, cardiac monitor, dynamap, syringe pump, and whichever electronic medical record system that is available. They [nurses] are not giving time to the patients…We monitor the patient's BP manually, but now we are switching towards the electronic system. So um, the nurses may not go to the patients, they see only the monitor, they may not talk to the patients…we just attach the cardiac monitor, and we record the objective data, and so we do not get the subjective data from the patients…all patients reported that caring behaviour is declining day by day… (SN-PR-3)

The findings indicate that the use of technology may improve efficiency in clinical practice, however, it decreases nurse-patient interaction and building rapport. Sometimes, patients and their relatives get frustrated when patient needs are not met, and they are not satisfied by the care nurses give.

5.2.3.10.4 Behaviour of patients and relatives

Participants talked about how inadequate resources in the public sector may have an impact on patient care. As a result, patients and nurses' behaviour may be influenced. Nurses make difficult decisions based on patient priorities to manage the patient and relatives' expectations. One of the nurses explained:

> … I receive pre-operative and post-operative patients. According to ethics and humanity…I should give more attention to the post-operative patient as

> compared to the pre-op patient…The post-op patient was in severe pain. That patient was on a stretcher, and I had to provide a bed for him. I asked the pre-op patient to share the bed with the other patient so that I could give a bed to the post-op patient…This patient was upset and annoyed, but quietly shared the bed with the other patient. But the next day, she complained about my action on the Citizen's Complaint portal, so I was asked by the administration to explain this act verbally and in writing. (SN-PU-8)

A patient from the private hospital explained that patient's urgent requirements are sometimes not met promptly because nurses need to discuss their concerns with doctors. This can take time and affect patient behaviour:

> I also understand, there are some requirements that they have to fulfil because they cannot decide on their own. They have to consult the doctor, and then come back. Some patients do not understand that part. They just think that if I have asked for something, they are supposed to give it to me immediately. (PA-PR-3)

However, a nurse from the public hospital stated that patients and relatives at times are frustrated or impatient and blame nurses because of delayed responses from the doctors.

> Blood transfusion is not allowed by nurses. She has to wait for the doctor to perform it. It hangs on the stand, patients get frustrated, and their attendants get frustrated too. This creates tension. Sometimes doctors do not transfuse blood as they are busy, or they are not available. Sometimes, the patient is serious and frequently, we call the doctors and they do not come, and meanwhile the patient dies. They [attendants] also blame nurses. It gives tension to the nurses. (SN-PU-15)

Because of the scarcity of resources in the hospital, delay in treatment by nurses and doctors, patients and relatives may display rude or inappropriate behaviour. All these factors eventually have an impact on how nurses interact with their patients. Personal issues of nurses may also impair their ability to demonstrate caring behaviour towards patients.

5.2.3.10.5 Nurses personal issues

Non-fulfilment of basic needs may affect job satisfaction. Nurses face multiple issues that may hinder demonstrating caring behaviour such as the non-availability of a day-care centre for their children, older nurses with health issues, and female nurses also have many responsibilities to fulfil at home. As the nurses from the public hospital explained:

> People expect nurses to communicate well, but a conducive environment is not provided. Provide the facilities in private, so they [nurses] feel happy…In the government sector, nurses have so many issues…. They do not have a day care centre. Their children are suffering because of that… Being a female, doing a job, and taking care of home is very difficult… they are frustrated and can become harsh to others. Furthermore, female nurses over 35 may have health issues such as high blood pressure, high blood sugar, joint pain, backache. No one understands that she is sick. After 50, they should have less responsibilities. She should avoid prolong standing or tough work. It all brings a change in their attitude. (SN-PU-15)

Furthermore, conflict between team members can also affect patient care, *"…we have to change ourselves and also be humble with each other…If we do not respect each other, our relationship with each other and the patient is affected." (SN-PU-10)*

Nurses have many personal issues that affect their health and their work behaviours. These factors may affect their motivation at work and hence their relationship with each other and the patients. Finally, another important factor that hinders caring behaviour by nurses is reciprocity. If the nurses expect patients to exert positive attitude towards them then they should show the same.

5.2.3.10.6 Reciprocity

Reciprocity was the last theme that emerged from the interviews. The patients expressed that health care is becoming increasingly expensive, particularly in private hospitals. The patients believed they were entitled to good care. Good care means that nurses are readily available to fulfil their needs even if they have other patients or responsibilities. This is illustrated with the following quote from a patient in a private hospital:

> This hospital is very expensive; it costs 5-6 lacs. Therefore, people want the facilities. If they [patients] do not pay much, nobody will take care of you, like in

> government hospitals. The person who is paying 6 lacs wants the treatment accordingly and it is their right. (PA-PR-6)

Patients from public and private hospitals commented about the need to have a positive attitude towards patients irrespective of patient behaviour. Nurses reacting negatively may affect patient mental well-being. This is illustrated by a patient's quote, *"If we are good then they [nurses] should show good behaviour. Means do not misbehave. If patients are not good with them even then they behave good with them, otherwise a patient may feel stressed…" (PA-PU-16)*

This section investigated the participants' expectations from nurses in terms of care. The findings indicated that patients' expectations in the private and public hospitals differed. Patients in the private sector expect a nurse to pay greater attention to them and respond to their needs more quickly. On the other hand, patients in the public sector expect good behaviour from nurses irrespective of how they are treated by patients. Therefore, nurses' actions appear to be sometimes contingent on the actions of their patients. The following concept will cover how nurses can be taught to demonstrate caring behaviour.

5.2.3.11 Teaching strategies

Using teaching strategies to teach nurses how to demonstrate caring behaviour towards patients was viewed by all participants as essential. One of the nurses stated, *"Nurses from diverse cultures with diverse attitudes require training to improve their caring behaviour." (SN-PR-5)*

Different teaching strategies were suggested by the participants to teach caring behaviour such as:

- motivating students by rewarding them for showing caring behaviour;
- encouraging students to conduct presentations about caring behaviour;
- role modelling (students observe positive behaviour of nurses and teachers on the ward);
- role playing;
- observing students.

A nurse and a student nurse suggested motivating nurses who demonstrate caring behaviour and encouraging students to conduct a session on the topic. *"We should reinforce caring behaviour by motivating nurses to strengthen their caring behaviour,*

build confidence, and give reward to those who illustrate good conduct as well." (SN-PR-5)

"…You ask the students to give a lecture on that. Tell them to prepare and give a lecture on it. When they prepare and give a lecture on caring behaviour, they will remember, and others will also learn." (ST-PU-2)

Many of the students emphasised the importance of role modelling:

> Nurse educators may emphasise caring behaviours to their students by demonstrating this behaviour in practice in the clinical setting and the school. When you go to your patient, when you talk to your patients, they [student] will see that in their own eyes. They will understand it better as they see it. (ST-PR-3)

A few nurses suggested using role plays as a teaching strategy:

> Through role-play, one student would act as a patient, one would be a relative and one would be a nurse and ask them to do a practical demonstration. So, when they act in front of you, the others will pick up points and learn. This way you can guide them. So, I think, practically, if they observe something, they will always remember it. (ST-PU-1)

One of the students suggested observing students while giving care to patients, *"When you assess students provision of care to patients, do not only assess how they collected the data, but also assess how they are providing care, and how they are behaving, and communicating with the patients." (ST-PU-2)*

This section explored different teaching strategies that were suggested by the participants that can be used to teach and inculcate caring behaviour in nurses. The next section will discuss about the findings of phase two and relate it with the previous literature.

5.3 Discussion of phase two findings

5.3.1 Introduction

The summary of the findings of the participants' interviews in phase two of this thesis is provided in this section. The key findings of the perceptions of caring behaviour among patients, nurses, and student nurses, and how these findings relate to the previous studies are presented. This section further explains the conceptual framework of caring behaviour and identifies the novelty in the current framework. Lastly, it concludes with a discussion of the rigour and the conclusion of the findings of phase two.

5.3.2 Summary of the findings

This study found that nurses have multiple responsibilities: they need to fulfil their promises to patients, act compassionately towards others, respond immediately, and fulfil patient's needs. It is also found that nurses are responsible for providing the best health care environment; that is taking care of noise, temperature, light, as well as cleanliness of patients. In addition, nurses are responsible for protecting patients from psychological harm by recognising and managing their distress or anxiety as part of caring behaviour. This study further found that nurses should get complete information about the patient's health condition and use critical thinking skills to resolve patient problems. It is also found that nurses must be competent and provide evidence-based care by considering patient's preferences, priorities, spiritual resources, and religious beliefs.

A nurse needs to be sensitive and respectful of diverse cultural needs of patients to allow nurses to plan care that is culturally compatible and patient-centered. A nurse should allow practices that are not harmful to the patients, otherwise, nurses need to explain why a certain practice must be avoided or not followed.

Nurses believe that a trusting environment can be developed by valuing patient privacy and keeping their information confidential. Demonstrating effective communication skills such as spending time with them, listening to their concerns, and use of therapeutic touch may help in developing interpersonal relationship.

The patients expected nurses to provide information regarding their health condition and treatment plan. This may relieve their fears and resolve their concerns. When educating patients, nurses require competencies such as being knowledgeable and aware of up-to-date information about a patient's health condition, past clinical experience, effective communication skills and confidence. Another important aspect of care is to enable the patient to be involved in their own care by assessing how much

assistance is required, educating, encouraging, and motivating them. Well informed patients may then be able to take informed decisions regarding activities of daily living.

In this study, certain unethical behaviours displayed by nurses were identified. These included being disrespectful to the patients and their families, incompetence in performing procedures, and failure to meet patient needs. These behaviours may contribute negatively to overall wellbeing and dissatisfaction with nursing care. These unethical behaviours may be explained by certain challenges such as an increased workload due to nursing shortages, an increase in paperwork, lack of resources, or having their own personal issues or health problems. Moreover, patients in the private hospital expected more from nurses in terms of caring because they pay extremely high fees for their treatment. This may differ from the public hospital where patients want nurses to demonstrate good behaviour even if the patients do not behave well. Hence, caring is multi-layered, and nurses need to understand the patient expectations. However, the implementation of caring behaviours is contextually dependent.

5.3.3 Discussion of the findings in relation to the wider literature

This study explored the perceptions of caring behaviour of patients, nurses, and student nurses. The findings provided essential information concerning the expectations and pertinent characteristics of nurses in Pakistan that can be used to improve caring behaviour and enhance caring relationships with patients. Some key findings are compared with the previous literature in this section.

5.3.3.1 Meaning of commitment and compassion in public and private hospitals

The infrastructure of public and private hospitals is explained in chapter one, section 1.2.2, under the heading of ‘Healthcare system in Pakistan.’ The majority of the participants, across all three groups from these two sectors described the theme, ‘commitment and compassion’ in the concept of ‘human trait’ in different ways. One of the student nurses from the public institution defined commitment as fulfilling responsibility regarding administration of medication, such as medicine dose should not be missed. However, a patient from the private hospital emphasised timely administration of medication and provision of best care.

Surprisingly, there is a lack of evidence in the literature reviewed in this study regarding commitment towards patients. However, Jafaragaee et al. (2012) explain that professional commitment means nurses are committed to provide the best care by having updated knowledge and competency in skills. If nurses do not know about something, they should search for knowledge and use this in their care of patients. In

addition, committed means development of interpersonal relationship with the patients, such as effective communication, respect, and support.

Additionally, there was also a broader variation in the understanding of compassionate behaviour by the participants of all three groups. A student in a private institution illustrated compassionate care through nurses keeping promises to patients and resolving their issues immediately. For example, if a patient complains of pain and asks for pain medication, and a nurse decides to give an injection, it should be provided immediately. However, the meaning of compassionate behaviour by a nurse in the public hospital was educating the patients about their health conditions.

Moreover, in the current study, participants from the private hospital, explained compassionate as demonstrating empathetic behaviour, such as treating the patients with the same respect with which nurses would want to be treated. The patient believed that word choice is an important issue when communicating with the patients. “The definition of compassion that refer to ‘suffering with’, to being confronted with the suffering of another and feeling motivated to respond to it” (Gallagher, 2015, p.843).

Nurses needing to show empathetic behaviour is also consistent with the previous studies (Andersson et al., 2015; Ferri et al., 2020; Petrou et al., 2017; Sundus and Younas, 2020b). Travelbee (1964) and Watson (1979) state that nurses can feel empathy and express those feelings and perceptions towards their patients. However, this behaviour was given low importance by student nurses, nurses, and patients from the medical and surgical departments (Labrague, 2012; Papastavrou et al., 2012; Afaya et al., 2017). A possible explanation for this might the heavy workload of nurses and the numerous numbers of patients hindering the nurse’s ability to show empathetic behaviour. In another explanation, nurses may not have been trained enough to demonstrate empathetic behaviour towards their patients. A patient in this study also considered nurse training on empathetic behaviour. This patient talked about the choice of words while communicating with patients, for instance, if a patient calls to the nurse for about being in pain, a nurse can respond that she understands their pain and will try her best to relieve the pain. She will consult with the doctor and come back to the patient as soon as possible. This could be explained as showing how an empathetic nurse behaves by understanding the health condition of the patients, showing willingness to help them, and finding the solution of their problems to promote their well-being (Ilarde et al., 2021).

5.3.3.2 Caring as a personal value

This theme is described under the concept of ‘Human trait.’ One of the student nurses believed that every nurse appears to have their own set of values that guide their actions. This can be interpreted as when the nurse’s personal values are compatible

with patient's values and the healthcare organisation, this may influence a positive behaviour. But the opposite may also apply. Participants emphasised that showing love to others, caring about them, and trying to improve the quality of their lives are all internal motivations (Dobrowolska and Palese, 2016). Many of the student participants said that caring was a quality they brought to their nursing education. They had the desire to improve individual's lives. Nevertheless, they recognised that both education and experience can benefit in the development of caring traits (Phillips et al., 2015).

5.3.3.3 Psychological distress among patients during hospitalisation

There are certain factors that cause psychological distress for patients which are highlighted by the participants of all three groups, under the theme 'Protecting from harm.' These factors are: patients unable to fulfil their responsibility at home, non-cooperative behaviour of family members or relatives, being unfamiliar hospital environment, financing of the medical treatment, unaware of the treatment plan, feeling lonely in hospital, and uncaring behaviour of nurses. Some of the factors identified in the literature (Chhari and Mehta, 2016; Abuatiq, 2020; Babaii et al., 2021), such as insufficient adaptability to the unfamiliar healthcare environment and financial issues, (being unable to bear treatment expenses) are consistent with the current study findings. Others are: inadequate privacy, exposure to unfamiliar procedural equipment, and stress due to the disease (Chhari and Mehta, 2016).

However, surgical patients in the literature have reported anxiety at the time of being discharged before they are fully recovered from their illness and unable to manage their own care (Letterstål et al., 2010). Consequently, there is evidence in the literature that anxiety can increase the likelihood of poor or unsatisfactory outcomes of treatment (Ghoneim and O'Hara, 2016).

Psychological distress is characterised as an unpleasant emotional experience brought on by a range of circumstances, including fear, tension, anxiety, and depression (Brody et al., 2015; Tola et al., 2015). Mishel (1988) introduced the concept of 'Uncertainty in Illness,' which means patients are unable to determine the meaning of illness, treatment, and hospitalisation, which may cause patient stress. Studies also show a positive association between the length of time a patient's needs are not fulfilled and their level of distress (Orlando, 1961).

These findings from the literature highlight the importance of developing psychological support measures to improve patient mental health. In the current study, the nurses and the patients believed that a nurse should take responsibility to support patients in reducing stress. They proposed different strategies to achieve this. For instance, one of the patients from the private hospital suggested that in order to support the patients to be well-informed regarding their treatment plan, a nurse can explain that she is going to

administer an intravenous infusion and then the laboratory assistant will take the blood sample. In this way, patients may mentally prepare for the treatment regime. Moreover, while administering medication, nurses need to inform patients about the effects of the medication. The literature also supports the finding that patients and caregivers should know the side effects of medication to reduce their anxiety (Rahman et al., 2019). A nurse can use different methods to alleviate patient's stress that can be as simple as orientating patients to the hospital environment if they are unfamiliar with the environment of the hospital. Stress can be reduced when a nurse skilfully performs clinical skills, especially, invasive procedures (Tsai and Wang, 2015; Mako et al., 2016). Nurses can also use diversional therapy such as keeping the patients engaged in reading a book, painting, or any interesting hobby.

Furthermore, teaching and informing patients about the expected outcomes of treatment prior to it may minimise their anxiety (Aasa et al., 2013). According to some studies, hospitalised patients find the presence of nurses helpful to overcome their worries and anxiety (Mohammadipour et al., 2017; Weyant et al., 2017). In the current study, the participants of all three groups suggested that nurses can create a friendly atmosphere by having a sense of humour such as telling good jokes to make the patients happy and relaxed, which can assist to create a bond with them and relieve stress. This finding is similar to those of Mako et al., (2016), Amy et al. (2012), and Costello (2017) whose studies showed that nurses utilise humour for two reasons: as a coping mechanism to meet the emotional needs of patients, and to support patients to engage with one another on a more personal level.

The findings of the current study regarding friendly behaviour are consistent with those who found that participants expect nurses to treat patients in a friendly manner, be kind, and be respectful (Mlinar, 2010; Labrague, 2012; Merrill et al., 2012; Omari et al., 2013; Youssef et al., 2013; McFerran et al., 2016).

5.3.3.4 Gender discrimination

In the current study, a patient expressed that nurses especially female nurses often do not provide guidance or advice to patients. This finding corroborates a previous study (Sundus and Younas, 2020) which explored the perceptions of caring behaviour of male nurses towards patients. The patients found male nurses to have good listening skills. They listened to patient's complaints and concerns and provided information they needed. It is difficult to explain this result, but it might be related to patients interacting with male nurses who were more knowledgeable about their health. Additionally, a further study revealed that male student nurses were also good at expressing caring behaviour. Being compassionate and sensitive was found to be compatible with the

male gender, hence it was not difficult for male students to exhibit caring behaviour (Cuadra and Famadico, 2013).

Male students in nursing programmes studied the same courses as female students did, including how to treat and care for patients well and how to communicate with them in a way that does not diminish masculinity (O'Lynn, 2013). Aupia et al. (2018) revealed that on several measures of caring, male students performed better than female student nurses.

In the Pakistani culture, most patients prefer care to be given by nurses of the same gender as themselves. This is also found in a previous study carried out in Pakistan where female patients sought help from female nurses and male patients easily shared their concerns related to urinary and reproductive health with male nurses (Sundus and Younas, 2020). The same gender preferences may be due to patient's everyday cultural norms and beliefs.

5.3.3.5 Assessing and facilitating spiritual practices

In this study, nurses assessed and facilitated patient's spiritual needs by offering resources for them to perform religious practices, such as prayer mats and holy books, playing recordings of holy verses, and calling spiritual leaders to counsel patients. This may help to cope with illness, promote mental well-being, and regain their faith. Omari et al. (2013) reported that for Muslims, religion focuses their thoughts and actions on God. For the patients, their religious beliefs and practices are important and considered to be spiritual needs. Muslim patients frequently engage in spiritual religious practises such as reading the Qur'an (Islam's holy book) and praying while they are ill. Spiritual practices may be helpful in reducing the emotional stress during illness. Therefore, nurses should respect patient's spiritual practices by giving them all they require to fulfil their religious obligations, respecting the time at which patients undertake these spiritual observances, and creating a suitable environment without interruption.

In the current study, nurses perceived that it was difficult for them to provide spiritual care because differences in beliefs. However, nurses in a previous study stated that they prayed with patients of different religions because they believed it would make them feel better (Costello, 2017). In short, nurses go beyond their comfort zone to provide spiritual care to patients who practise a religion other than their own. Nurses need to support patients in the fulfilment of their spiritual needs. Patients may experience depression and a reduced sense of spiritual wellbeing if their spiritual needs are unmet (Costello, 2017).

In addition, all three groups of the participants in this study reported inspiring hope as a caring behaviour. It involves encouraging or reassuring the patients about their health

condition. One of the patients from the public hospital explained how nurses can instil hope in the patients by saying, ‘nothing will happen, there are many people, who are getting the same problem, do not lose hope.’ The present findings seem to be consistent with other research studies which found communicating about possible positive outcomes can help patients feel more relaxed and hopeful (Tsai and Wang, 2015; Thomas et al., 2019).

While the terms spirituality and religion are sometimes used interchangeably, the two are not synonymous. A person might be extremely spiritual without being affiliated to any particular religion. In order to fulfil the spiritual needs of the patients, religious beliefs may or may not be incorporated. In other words, spirituality for some patients may be non-religious, while for others, spirituality is religious in nature. Thus, spiritual needs extend beyond religious beliefs and are highly personalised for each patient (Sartori, 2010).

5.3.3.6 Respecting patient values and beliefs

In the current study, the patients from both public and private hospitals felt that a nurse should not address them by their name. The patients suggested that if nurses want to call out the name of the older patients, they should call them ‘sir’ or ‘baji’ or ‘aunty’, rather than just calling out a name. In the Pakistani culture, it seems quite disrespectful when nurses call the name of the patient. A study by Labrague (2012) conducted in Philippines explored patients’ opinion about the caring competencies of baccalaureate nursing students and found that most of them expected nurses to ask them how they would like to be addressed.

There are two different ways of addressing patients: formal and informal (Parsons et al., 2016). Formal can be sir or madam and informal includes uncle or aunt for older patients. Addressing patients formally demonstrates acknowledgement of the patient’s identity and self-respect (Özcan, 2012). The study by Şimşek Arslan et al. (2019) explored how nurses addressed their patients in the Turkish culture and found that they usually address them formally (59.1%), but 66.1% of patients, on the other hand, preferred that nurses address them informally. In any culture, appropriately pronouncing a person's name can be indicative of respect for others. Hence, in the initial interaction, a nurse addresses patients by their first and surnames and later, may inquire about how they would like to be addressed (Sheldon, 2009; Özcan, 2012).

In Pakistani nursing institutions, the undergraduate nursing curriculum teaches student nurses about communication with patients, including formal way of addressing them in order to maintain nurse-patient relationship. This is also consistent with the findings of other studies (Şimşek Arslan et al., 2019). However, in the current study, older patients preferred either way of addressing them.

In the current study, the participants emphasised that nurses should show their concern for the patients by providing therapeutic touch. Similar results have been found in earlier studies (Pearcey, 2010; Youssef et al., 2013; Andersson et al., 2015; Phillips et al., 2015; Petrou et al., 2017). The participants described ways to provide therapeutic touch by holding patient's hands and touching their arms and forehead (Pearcey, 2010; Petrou et al., 2017). However, in other studies, patients, nurses, and student nurses from the medical, surgical, and coronary care departments considered therapeutic touch to be the least important aspect of care (Merrill et al., 2012; Omari et al., 2013; Youssef et al., 2013; Andersson et al., 2015; Flynn, 2016; Kalfoss and Owe, 2017). This could be explained by the wide variety of patients from various cultural backgrounds with different norms and values may make it difficult for the nurse to use therapeutic touch in their practice.

There are different types of touch: instrumental, protective, and expressive (O'Lynn and Krautscheid, 2011). Instrumental means performing procedures or providing direct care such as changing a dressing, and bathing. Protective touch prevents a patient from harm, for example, a patient removing a nasogastric tube or cannula. Expressive touch is used for showing compassion and support. For example, holding hands of a dying patient or placing a hand on patient's shoulder to reassure them and relieve their anxiety (Stonehouse, 2017). Another type of touch is therapeutic touch. This is often used in conjunction expressive touch. Therapeutic touch is a complementary therapy for patients to promote relaxation by reducing pain and anxiety. Despite the term 'touch', there is no physical touching (Kozier et al., 2012; Stonehouse, 2017). Expressive touch shows a caring or loving relationship with the patients. Nurses can transmit warmth and care by placing their hands on the patients (Chamley and James, 2013).

Russell (2011) highlights the relevance of touch in assisting someone who is grieving or bereaved. When a patient is grieving, it can be difficult for the nurses to say something; words can seem meaningless at times. Often, being present is more essential, and a soothing touch can speak thousand words. However, touching is not always welcomed by the patients especially the opposite gender. It is important for nurses to be mindful about patient's preferences, cultural values, and beliefs, and also gain consent from them for the use of expressive touch (Stonehouse, 2017).

5.3.3.7 Building a trusting relationship

In the current study, nurses from the public hospital believed that a trusting relationship with patients can be built by talking to them, discussing their illness, resolving their queries, maintaining confidentiality of patient information, responding in a polite manner, and introducing and greeting the patients. After building a trusting relationship,

patients are more willing to engage with what nurses advise them to do. However, other studies mention that in order to build trusting relationship, nurses need to be physically present with the patients. Patients may not trust nurses or make a connection with them until they know them (Costello, 2017) and understand that nurses will keep their information confidential (Mlinar, 2010; Papastavrou et al., 2012; Youssef et al., 2013; Ferri et al., 2020). This helps open communication between patients and nurses.

A study conducted by Vanneste et al. (2013) revealed that a trusting relationship was built between patients and nurses when patients were cared for by the same nurses for several weeks. However, if building a trusting relationship with the patients requires longer exposure with the same nurse then gaining trust may be difficult for nurses delivering care in a shorter period of time (Thomas et al., 2019).

A trusting relationship is to convey a sense of understanding and commitment for patients, which is rated lowest by the year one and the year four student nurses in previous studies (Labrague, 2012; Zamanzadeh et al., 2014). It could be argued that in the initial year, students may be at the early stage of developing skills, but in the final year, their skills may be more developed in the transition phase of becoming a registered nurse. A study conducted by Ambrosi et al. (2021) of students on a three years programme considered establishing trusting relationship with the patients as important and found that students performed this behaviour frequently during their clinical practice.

5.3.3.8 Role in educating and supporting patients to become independent

In this study, nurses believed in educating, motivating, and encouraging patients to become self-sufficient in their care both during and at the time of discharge. A number of perspectives were expressed. For instance, the majority of the patients considered educating patients regarding their current situation, treatment, and medication as showing caring. It is important that nurses teach patients about their illness especially when it is the first time they are ill. Nurses need to guide their patients according to their level of knowledge, so that they can fully understand how to take care of themselves properly. These findings are consistent with previous studies that revealed the importance of providing patients and family with information regarding the disease, its treatment and how to deal with the health issues. This may help them to participate in their care and make an informed decision about their health problems (Mlinar, 2010; Youssef et al., 2013; Modic et al., 2014; Esmaeili et al., 2016; Mako et al., 2016).

In this study, it was suggested that patient participation may improve when information was shared during the bedside handover so that they can learn about self-care and

take an active role in it. Sharing information between the nurses during the bedside handover may strengthen the patient's trust (Mako et al., 2016).

In another finding from this study, patients reported that the nurses gave them information, but they did not ensure that the patients understood the information. A survey conducted by Thomas et al (2019) found that patients rated nurses with low scores if they only provided information for patients but did not ask about their knowledge and understanding of the disease. It could be argued that because of time constraints, nurses do not enquire whether the information patients are receiving is understood or not. In contrast, nurses from the coronary care department in a previous study perceived that they clarified the queries raised by the patients, asked about their understanding, and helped them plan a realistic goal for their health (Omari et al., 2013), and nurses from medical and surgical departments helped patients achieve their goals (Youssef et al., 2013).

In the current study, one of the nurses from the private hospital considered how to enhance the self-efficacy of the patients. According to Bandura (1977), self-efficacy is the judgment of personal capability to be involved in health-promoting behaviour. Once able to demonstrate self-efficacy, the patient may initiate and perform self-care activities to maintain a healthy lifestyle, growth and development, and well-being (Orem, 2001). According to student nurses in previous studies, nurses support patients to perform daily activities such as doing exercises or taking a bath (Mlinar, 2010; Flynn, 2016; Petrou et al., 2017). Nurse theorists also suggest giving patients information, building strength and self-control, and supporting them to gain independence as early as possible (Henderson, 1964; Watson, 1979; Levine, 1996).

In this study, one of the students stated that some nurses did not make an effort to support patients to become self-sufficient in their care. This behaviour is also given low importance by nurses from surgical and coronary care departments (Papastavrou et al., 2012; Omari et al., 2013; Roulin et al., 2020). This may be attributed to the fact that patients in some departments are highly dependent on nurses. To avoid any negative outcomes, nurses often do not encourage patients to be self-sufficient.

Furthermore, the provision of information was valued by participants from all three groups in this study because it allowed patients to actively participate in their health decisions. This finding supports previous research, which found that a patient and family should encourage patients to be autonomous to make independent decisions (Amy et al., 2012; Merrill et al., 2012; Dobrowolska and Palese, 2016; Esmaeili et al., 2016; Li et al., 2016; Mako et al., 2016).

However, in the present study, a student said that family members are responsible for making decisions on behalf of patients in Pakistan. A possible explanation for this

might be that obtaining health-related information and decision-making may be difficult for patients because of their health conditions. They need someone to support them to help them decide about their health. In South Asian contexts, religion, culture, and the social support system all contributed to the important role in decision making by family (Rahman et al., 2019). This indicates that patients are not always involved in the decision making for major issues such as surgery. However, in the current study, nurses helped patients to take decisions on small tasks, for instance, observing the IV line for swelling and informing the nurse or selecting the vein for IV cannulation.

5.3.4 Overview of caring conceptual framework

This section will explore the conceptual framework which has been developed based on the findings from the current study (Figure 9). A conceptual framework usually discusses the relationship of different concepts with the main idea or concept (Adom et al., 2018) which for this study is caring behaviour. In this framework, all the core concepts are brought together and the relationship between them identified with the support of literature.

Figure 9: Caring conceptual framework

The caring conceptual framework derived from the findings of this study is consistent with previous studies. However, it is unique in terms in providing a comprehensive and holistic approach to patient care in the Pakistani culture. Meeting the patient need

cannot be accomplished by these concepts separately as they are all essential in demonstrating caring behaviour. Furthermore, according to the findings, nurses can adopt some strategies such as instilling hope in their patients, building a trusting relationship with them, using a diversional therapy, fulfilling the spiritual needs, and orienting them to the unfamiliar environment to reduce fear. Trust can be built if nurses maintain patient dignity, respect their cultural and religious values, and beliefs so they can share with the nurses their feelings, concerns, expectations, preferences, and needs.

Moreover, this conceptual framework describes the caring process including a comprehensive and holistic approach to patient care that executes physical, psychosocial, and spiritual nursing interventions. These interventions not only advocate patient needs, but also empower them to be self-sufficient in self-care (Leininger, 1981; Swanson, 1991). This framework describes attributes of caring process such as empathetic and compassionate behaviour, attentively listening, maintaining eye contact (Eriksson, 1997), use of expressive touch, reassurance and reducing fear, developing trusting relationship (Leininger, 1993), providing personalised care (Leininger, 1981; Swanson, 1991), culture sensitive care (Leininger, 1981), providing information, encouraging patients to express their concerns, and helping them cope with psychological distress.

Caring is dependent on the professional expertise of the nurses, such as being knowledgeable, competent in nursing skills, confident and possessing decision making skills. Moral values are also important such as commitment and responsibility for patient care, all of which are identified in theories of caring (Carper, 1975; Benner et al., 2009; Watson, 2009). Another factor promoting caring behaviour is ensuring a conducive working environment with adequate nurse resources and sufficient time to carry out caring activities. Furthermore, allowing reciprocal relationships to develop, teamwork and support from other staff are also considered necessary. Caring can be a human trait, but it needs to be cultivated through learning experience in the clinical area and professional education. Hence, through nurses exhibiting caring gestures and other caring behaviours, patients may experience improvement in their mental and physical wellbeing (Leininger, 1981).

5.4 Rigour of the study

Rigour is a standard to assess the trustworthiness of the data in qualitative studies (Lincoln and Guba, 1985). Trustworthiness criteria such as credibility, dependability, confirmability, and transferability can be utilised to assess the quality standards in

qualitative research design. Table 14 summarises the criteria with actions to ensure rigour in phase two.

Table 14: Criteria for rigour of the study

Criteria	Actions taken
Credibility Self-assurance in the accuracy of the data and its interpretation. It is the truthfulness of the data (Lincoln and Guba, 1985; Anney, 2014; Pandey and Patnaik, 2014)	• This was ensured by rapport building and developing a trusting relationship with the participants, so that they could share and express their perceptions and experiences openly. This is illustrated by data using quotes from the participants (Finlay, 2006). • Face to face and online semi-structured interviews were conducted during which I was objective in my approach in investigating the perceptions of participants and was value-free (Ritchie and Lewis, 2014). • Planned and unplanned probing and repetition of questions was done for clarification and expansion of information. Non-verbal gestures were also noted in the field notes. • Frequent feedback from the supervisors on my interviewing skills helped me to improve the process of data collection to get in-depth data from the participants (Korstjens and Moser, 2018).
Dependability Reliability of the study findings that could produce the same result multiple times in different settings and context (Lincoln and Guba, 1985; Pandey and Patnaik, 2014).	• Triangulation refers to the collection of data by using various sources and methods to verify the data and maintain integrity of the participants' data (Anney, 2014). • Different types of triangulations were used for ensuring the accuracy and completeness of the findings. For data triangulation, data were collected from multiple sites and persons (multiple departments of the hospital, public and private hospitals and nursing institutions) and patients, nurses and student nurses (Denzin and Lincoln, 2018). For investigator triangulation, the supervisors gave expert feedback in every aspect of the study (Kimchi et al., 1991; Duffy, 2009)
Confirmability The neutrality of the study findings that illustrate participants' perceptions and not the researchers (Lincoln & Guba, 1985)	• Reflexivity- Self-reflection was done using a reflective journal to examine my beliefs and assumptions regarding phenomena which may affect the research findings (Hesse-Biber and Piatelli, 2007; Polit and Beck, 2012; Parahoo, 2014). • To ensure accuracy of data, audio taped interviews were listened to repeatedly, field notes reviewed and verified with the transcripts (Guba and Lincoln, 1994). • In order to ensure rigour, the supervisors assessed the coding matrix, coding index, development of core concepts and transcripts from which the matrices were developed. Changes were recorded and feedback incorporated. • The text findings are presented and supported by quotes from the participants. • Careful records were kept of all stages of the data analysis process (Gale et al., 2013).

Transferability The applicability of study findings in other settings or context (Lincoln and Guba, 1985; Anney, 2014)	Transferability was ensured by having a detailed description of the study process and findings that could be made available to others in order to apply in similar situations. This would permit the reader to decide whether the findings could be relevant to other settings with similar groups of participants and context (Guba and Lincoln, 1994).

5.5 Chapter conclusion

This study aimed to explore the perceptions of caring behaviour among patients, nurses, and student nurses. One of the most important findings to emerge from this study was that the participants reported positive care experiences with the nurses. The participants recognised that demonstration of caring behaviour was an important aspect of clinical practice. This may play a very important role in patient safety, well-being and promote quality care for patients. These findings enhance our understanding of caring behaviour perceived by different stakeholders. The present study contributes to the evidence-base with respect to dealing with patients with psychological distress and helping the patients to self-care.

The present study makes several noteworthy contributions in the field of education, clinical practice, and research in Pakistan. Firstly, this work contributes to the existing knowledge of caring behaviour by providing a caring conceptual framework in an easy and understandable manner.

Secondly, these findings have been used to develop an educational programme to help nurses to increase their knowledge and apply it in their clinical practice.

Thirdly, this research will serve as a base for future studies related to caring behaviour by exploring caring concepts and its themes in detail. Some of the challenges emerging from the findings relate specifically to a lack of a conducive environment such as increased workload, which may hinder nurses from demonstrating caring behaviour. Overcoming these challenges while difficult, may allow nurses to exhibit caring behaviour and improve both patient care and the image of the nursing profession.

Hence, in healthcare, nurses need to promote a combination of physical, cognitive, and expressive aspects of care and also provide care based on the patient preferences and expectations. The traits of a caring nurse in this study can be utilised as a framework for teaching nursing students and practicing nurses to strengthen their interactions with the patients.

Chapter 6

Phase three: development of an educational programme

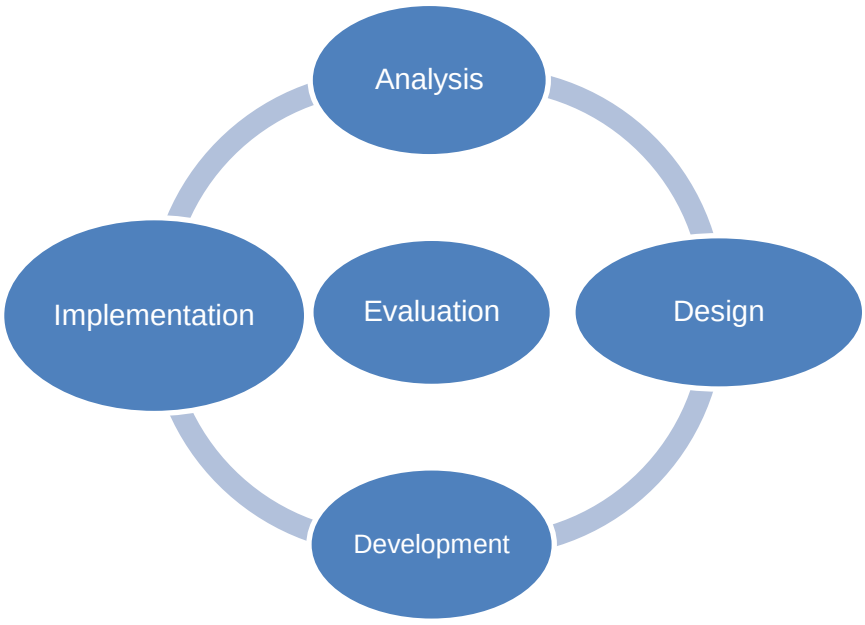
6.1 Introduction

This chapter reports on the development of an educational programme. The goal of this programme was to assist nurses in rediscovering, reinforcing, and refocusing their professional practice around caring behaviours (Bellier-Teichmann et al., 2022). The educational programme was developed based on the Caring Conceptual Framework from phase two of this thesis. The importance of using the findings from phase two of this thesis was to ensure that the educational programme was contextualised to the experiences of the patients and nurses in Pakistan. The ADDIE model was used for the development of this educational programme, which comprises five phases: analysis, design, development, implementation, and evaluation. The first two phases; analysis and design including consultation with the stakeholders for the proposed educational programme were completed and are reported in this chapter. The details of remaining three phases of ADDIE model are also provided in this chapter for future implementation and research. Finally, this chapter summarises the development process of the educational programme.

6.2 ADDIE model

The ADDIE model, developed by Branson (1978) was described in chapter two. It has five phases as illustrated in Figure 10.

Figure 10: Process of development of an educational programme



6.2.1 ADDIE phase one analysis

According to the first phase of ADDIE model, information is collected about the learners' needs in terms of knowledge, skills, or attitudes. Learners' needs can be assessed through numerous methods, such as focus groups (Zundel et al., 2015), individual interviews and questionnaires or surveys (Ahn et al., 2017). In this study, the learning needs in terms of caring behaviours were identified by conducting interviews with the patients, nurses, and student nurses in phase two. The learning needs in terms of knowledge, attitude and skills regarding caring behaviours informed the learning objectives for the proposed educational programme.

6.2.2 ADDIE phase two design

The second phase of the ADDIE model was to develop a detailed plan of the educational programme (Cheung, 2016). This educational programme developed during a one-year period from June 2021 to June 2022 using the ADDIE model. The proposed educational programme of this study included the course objectives, content, teaching methodologies, and assessment criteria (Matkovic et al., 2014). To produce optimal learning outcomes, Gagne's model of instructional design (Gagne, 1974) was used to assist with the design of the educational programme to promote appropriate cognitive processes (Khalil and Elkhider, 2016). Gagne's model is based on the information processing events that occur in a systematic manner to achieve the learning outcomes (Khadjooi et al., 2011). It consists of nine events to enhance the learner's learning: gaining attention, informing the learner about the objectives, stimulating recall of prerequisite learning, presenting the stimulus material, providing learning guidance, eliciting the performance (practice), providing feedback, assessing performance, and enhancing retention and transfer of knowledge (Gagne et al., 1998). The total learning time including teaching content, self-directed learning and resources required for the completion of each objective are added in the proposed educational programme (see Appendix J).

6.2.2.1 Gagne's model of instructional design

The caring-based educational programme for nurses was designed to be delivered once a week for four weeks. This optimal duration has been suggested by Delmas et al. (2018) in their mixed-methods clustered randomised controlled trial to examine the effectiveness of an educational programme using a humanistic approach to quality nursing care. In this thesis, there are fourteen sessions with 30-120 minutes allocated for each session, with a total duration of 14 hours of face-to-face teaching. Further, the non-contact hours required by the learners for self-directed learning including, writing three reflections and reviewing three articles will be approximately 60 min each

respectively, making the total of six hours. At the end of the session, learners will fill the questionnaires to evaluate their caring behaviours and the educational programme. The time required for the evaluation will be approximately two hours. The overall duration of the educational programme will be 22 hours. For teaching and learning sessions, a specific time was allocated for each objective, based on the depth of the content and complexity of learning behaviour (Fitzgerald, 2012). For example, 120 minutes were allocated for teaching caring concepts, which requires a detailed discussion with the learners and 60 minutes were allotted to teach the process of writing a reflection. In the first week of the session, the learners are required to complete a self-report questionnaire related to caring behaviours. The same questionnaire will also be administered at the end of the programme to evaluate their caring behaviour.

In accordance with the first event of Gagne's model, the researcher plans to gain the attention of the learners by using stimulating strategies such as thought-provoking questions, case scenarios, and images related to caring. Such activities develop curiosity to motivate the learners to learn the theory.

In accordance with the second event of the Gagne's model, objectives for the educational programme were developed in this study and will be shared with the learners when the educational programme is implemented (see Appendix J). The objectives for teaching the caring concepts were developed based on the findings of phase two. Sharing the objectives with the learners may help them to understand the learning expectations of the course. The format of writing objectives was based on Bloom's Taxonomy (Bengamin et al., 1964).

In the third event of stimulating recall of prerequisite learning, when the programme is implemented, the learners will be asked to share their past knowledge and experiences and integrate new information. This facilitates the learning process.

In the fourth and fifth events, presenting the stimulus material and providing learning guidance by using a variety of teaching strategies. Different caring concepts and its related behaviours will be discussed with the learners. Various teaching strategies may help to achieve the learning objectives while accommodating the learning style preferences of individual learner. Multisensory approaches may increase skill acquisition and retention of information (Fitzgerald, 2012). These include interactive lecturing; reflection; questioning; clinical simulation (case scenario, video, role play); journal club, and group discussion. These strategies have some advantages and disadvantages and other methods to combat the drawbacks of teaching can be employed by an experienced educator.

6.2.2.1.1 Advantages and disadvantages of teaching strategies

According to Snell et al. (2009), interactive lecturing involves interaction between the lecturers, learners and the content of the lecture. It can encourage active learning and promote attention and motivation; however, this may be time consuming. Determining the contribution of each learner is challenging because not all learners participate in the class (Atanasescu and Dumitru, 2013). This can be overcome by allocating time for interactive sessions and encouraging non-participating learners by asking questions.

According to Connie (2019), writing a reflection invites students to explain and analyse significant events that they have witnessed or experienced in the clinical context. It promotes learning by encouraging the learners to think critically about their clinical experiences. However, learners may spend a significant amount of time writing reflections and educator needs to examine these reflections. This may be overcome by asking the learners to write three reflections throughout the educational programme and to discuss those in a group along with their learning experiences. When nurses are involved in reflecting their behaviour, this may prepare nurses to establish caring relationships, consequently, improve patient outcomes (Finch, 2008; Glembocki and Dunn, 2010). For this educational programme, Gibbs (1988), reflective cycle was incorporated in the proposed educational programme to provide learners with a structured way of writing the learning experiences. The cycle has six stages as seen in Figure 11.

Figure 11: Gibbs reflective cycle

Buchanan (2016) states that questioning is a form of inquiry that evaluates a person's thoughts. This promotes active learning by boosting the learner-educator interaction to discuss concepts, encourage diverse points of view from the learners, and create opportunities for them to share their experiences. Nevertheless, it necessitates that learners and educators have a deep understanding of the materials. It is hoped that after attending the theoretical session on caring behaviour, the learners will have a stronger comprehension of the subject and be able to express their ideas.

According to Farashahi and Tajeddin (2018), clinical simulation is utilised to provide the learners with hands-on learning opportunities. Simulations can be used as a teaching tool or for evaluation and assessment, for example, case scenario, video, and role play.

Case scenario can provide an in-depth analysis of a real-life situation. This strategy allows the learners to integrate theory with real-life situations as they develop solutions to the problems; however, case development is a time-consuming and difficult task and educators are required to have good questioning skills while discussing scenarios. For this educational programme, case scenarios may be developed based on the findings of the interviews with the participants in phase two. In addition, as an experienced educationist, the researcher had the expertise to ask the learners critical questions about the clinical scenarios.

The use of videos was considered to encourage the learners to analyse and interpret what went well and what might be improved, for example, identifying caring and uncaring interactions with the patients (Clive and Alex, 2011). According to Connie (2019), finding videos is time consuming, and watching those videos may also take class time and require some additional equipment. But for this educational programme, videos may be developed based on the findings of the interviews in phase two of the study. Student actors could be hired to create videos of small duration using equipment such as a sound system and multimedia already provided in the educational setting.

Role play is a dramatic technique in which people take on the roles of others (Connie, 2019). This strategy allows the learners to integrate theory with real-life situations as they create solutions to the problems (Farashahi and Tajeddin, 2018). The role play increases observational skills, improves decision making skills, and enables the learners to comprehend the human behaviours needed to connect with in patient care (Gordon et al., 2012). Conversely, learners may be reluctant to act, and educators may require time to develop scenarios (Hamdani, 2018). Script for the role play may be developed based on the findings of the interviews in phase two of the study. Student actors may be hired to perform role plays.

Topf et al. (2017) describes how a journal club systemises, reviews, and construes the published literature and disseminates the findings for wider use. For this educational

programme, the journal club leader (researcher) identifies relevant articles for discussion. However, finding appropriate literature linked to the subjects being covered takes time (Connie, 2019). This may be overcome by using the articles, which were reviewed in this study. Articles may be circulated to the learners for discussion two weeks prior to the session.

Group discussion is a form of cooperative learning in which peers share their thoughts, allowing for comprehension and application of knowledge (Malakouti, 2010). Learners may be actively engaged to discuss videos, articles, and images relating to nurses' caring and uncaring behaviours. However, the learners need to possess sufficient knowledge for active participation in the discussion and comprehension of the concepts (Khalid et al., 2018). Learners may gain in-depth knowledge through theoretical sessions on caring behaviours to enable them to participate more meaningfully in the group discussions.

After presenting the content through different teaching strategies, in the sixth event, the learner is expected demonstrate the learned skills or behaviours for example by performing role play. This may provide an opportunity for learners to confirm their understanding of their behaviours. For example, learners can perform a role play on how to communicate with the patients in a polite and cheerful manner and how to explain the treatment plan to them.

In accordance with the seventh and eight events, the researcher may assess the learner’s performance, provide immediate feedback and guidance, and answer queries.

The ninth event focuses on enhancing retention and transfer of knowledge over a longer period of time. The teaching content should be relevant to practice, enabling the learners to implement it in the real world and write reflections on their learning experiences. Learners will write three reflections and discuss them at the start of each taught session at one-week intervals.

The next section provides detailed information of the educational programme, including the course description, objectives, and teaching content (see Table 15). This has been developed based on the Caring Conceptual Framework from phase two of this thesis.

6.2.2.1.2 Caring conceptual framework

Course Description

This course provides registered nurses and student nurses with a broad overview of the caring concepts and skills. The course is based on the Caring Conceptual Framework (from phase two of this thesis), identifying caring behaviours which are important for clinical practice and in their personal lives.

Learning Outcomes

At the end of the programme, the learners will be able to:

- Identify the different caring concepts and caring behaviours.
- Assume responsibility for initiating a caring attitude towards the patients.
- Apply learned knowledge into clinical practice.

Teaching content

The development of core concepts and themes in phase two (see core concepts and themes in chapter five, section 5.2.2), informed the development of teaching content for the educational programme for the nurses. The caring concepts and related caring behaviours are related to clinical practice. This programme was developed to improve the knowledge and understanding of nurses regarding caring behaviours. Table 15 describes the course content including eight caring concepts and related behaviours based on the Caring Conceptual Framework from phase two of this thesis, such as, human traits; showing interest in patient health; professional knowledge and skills; consideration of spiritual needs; culturally sensitive care; interpersonal relationships; role in supporting and educating the patients and supporting the patients to be independent.

Table 15: Course unit: caring conceptual framework

Caring concepts and objectives	**Caring behaviours**
Human trait	
Display professional commitment and compassionate behaviour towards patients.	Nurses should: • Fulfil their promise or commitment to the patients. • Treat patients with respect by communicating in a polite manner. • Respect their expectations and preferences. • Be empathetic towards the patients.
Showing interest in patient health	
Show interest in patient health.	Show concern for the patients (nurses need to encourage the patients to talk about their feelings, preferences, and concerns regarding their health condition. • Ensure a neat and clean environment around the patients. • Safeguard patients against mishaps such as injury and dehydration.

Apply stress relieving strategies to reduce psychological distress in patients.	• Use humour and be cheerful while communicating with patients. • Decrease patent anxiety through explanation of the treatment plan. • Use diversional therapy to relieve the patient's stress.
Professional knowledge and skills	
Integrate updated knowledge into practice.	Integrate evidence-based practice.
Share patient's issues with the healthcare professionals.	Speak with the health care team members on behalf of the patients for various issues.
Assist patients in physical care activities.	Assist patients in activities of daily living such as positioning, back rub, toileting, and bathing.
Respond to patient needs.	Promptly respond to patient's problems and fulfil their physical needs.
Evaluate the care being provided.	Observe the progress of patients following treatment such as medication.
• Perform the tasks on time. • Complete the paperwork before any procedure.	• Provide routine treatment on time such as medication and nasogastric (NG) feeding. • Do paperwork before sending the patients for the procedure.
Perform the skills competently.	• Know how to give injections and IV cannulation. • Manage equipment such as suction machines, etc.
Consideration of spiritual needs	
Assess the spiritual needs of the patients.	Identify spiritual needs and any signs of spiritual distress.
Perform interventions to meet the spiritual needs of the patients.	• Assist the patients in their religious rituals. • Providing care without discrimination.
Culturally sensitive care	
Assess the cultural needs of the patients.	Assess the cultural needs of the patients.
Perform culturally sensitive care.	• Provide cultural care when safe for the patient. • Be aware of the cultural practices which may be harmful to the patients. • Address the patients and relatives according to their preferences. • Ensure privacy for patients while performing any procedure. • Get approval from the patients about taking care given by nurses of the opposite gender.
Interpersonal relationships	

Build a trusting relationship with patients.	• Keep patient's information confidential. • Introduce themselves to the patients. • Spend time and listen to the patient concerns.
Demonstrate effective communication skills while interacting with the patients.	• Be polite and humble with patients. • Smile and maintain eye contact. • Hold patient's hand, touch their arm and forehead if the patient's culture allows so. • Do not react to a patient's irritating behaviour
Role in supporting and educating patients	
Explain the patients about their health condition and treatment plan.	• Provide information for the patients about their treatment and health condition. • Encourage patients to ask questions and clarify their queries. • Ask questions to ensure understanding about the information being provided. • Explain clinical procedure to the patients.
Recognise the need for involving patients in decision making.	Support the patients to make informed decisions regarding their care.
Supporting patients to be independent	• Educate the patients to empower them in their self-care. • Enhance self-efficacy through motivation and building confidence. • Include the patients in planning their care.

6.2.3 Consultation with key stakeholders

This section describes the consultation with key stakeholders. Matkovic et al. (2014) recommend consultation with the stakeholders to get their input on the overall educational programme and its teaching content. This section also presents the summary of the stakeholders' feedback and the modifications to the proposed educational programme.

Stakeholders were invited based on their expertise and/or had experience with the phenomena under investigation and who were willing to provide feedback on the educational programme (Etikan et al., 2016). The committee of stakeholders consisted of nine members (see Table 16).

Table 16: Expertise of stakeholders

Stakeholders	Expertise
Dean of the college	Manages the educational institution, responsible for the implementation of the nursing curriculum effectively and is an experienced researcher.
A nursing faculty member	Has experience of working as a bedside nurse, supervises the student nurses in the clinical settings, and has good hands-on clinical teaching experience.
Student nurses (2)	Final year male and female student nurses from public and private hospitals, with the experience of caring for the patients.
Registered nurses (2)	Experienced male and female nurses from public and private hospitals, directly involved in patient care.
Nurse Manager	Involved in the implementation of policy and day to day matters in patient care.
Lay representatives (2)	Male and female patients who have been admitted in the public and private hospitals and received care from nurses.

The meeting was held on 5th July 2022 and lasted for two hours with the purpose of presenting the research findings from phase two of this thesis and the first draft of the educational programme. The meeting started with members of the group introducing themselves, sharing the agenda and explaining the roles of the committee. The findings of phase two were presented. Following this, printed copies of the educational programme were distributed for review and feedback. Permission was taken to record the participants' responses. This was followed by a detailed discussion on the proposed educational programme. To focus the discussion, seven main questions along with a few probing questions were developed (see Appendix I).

The learning objectives, teaching strategies, content, and teaching materials were shared with the stakeholders to determine the relevance and their views on the practicality of the proposed educational programme (Krystallidou et al., 2018). Based on their feedback, the proposed educational programme was refined. The participants suggested that some action verbs in the objectives need to be changed, which are shown in Table 17.

Table 17: Modification to educational objectives

Previous	Modified
Show interest in patient health.	Demonstrate interest in patient health while caring for patients.
Perform culturally sensitive care.	Demonstrate cultural sensitivity while caring for patients.
Perform the skills competently.	Perform psychomotor skills competently.
Integrate updated knowledge into practice.	Integrate evidence-based practice.
Build a trusting relationship with the patients.	Exhibit a trusting relationship with the patients.

6.2.4 Summary of stakeholders feedback

A summary of feedback from the stakeholders is detailed below:

- Participants thought that student nurses are being taught only the cognitive aspect of caring and not expressive care. They recommended that the content of caring behaviours and teaching and evaluation strategies should be integrated into the undergraduate programme. For example, the researcher will add the course of the educational programme of this thesis in the existing course content of 'Fundamentals of Nursing', which is being taught in the first year of BSN programme.
- They also emphasised continuing education for nurses about caring behaviours. This course can be included in the nurse orientation programme. The researcher agreed that newly qualified nurses should be trained in the orientation programme in the hospital settings. Furthermore, this may be added to the in-service continuing educational programme.
- Participants suggested teaching nurses how to integrate evidence-based practice in patient care. The researcher will add the content of evidence-based practice to the course content of this educational programme.
- They suggested using videos based on the caring concepts that can be utilised in the undergraduate and graduate programme. It can be used in the course, 'teaching for critical thinking' of the MSN programme. It can be shared with other colleges as well. They further suggested MSN students who take the 'Educational Practicum' course, should be given assignments for developing videos based on caring concepts. A scenario can be taken from the study findings, of both public and private hospitals, as patient's demands are different in both hospitals. The researcher acknowledged their suggestions, as experience

of receiving and giving care is different in both public and private hospitals. These videos could be usable products and should be shared with other colleges.

- Using journal club as a teaching strategy for bedside nurses could be difficult. Nurses may find difficulty to review the articles but feasible for managers to understand the concepts in the articles because they might be more knowledgeable and involved in research activities. The researcher disagreed with the suggestions and directed them to the proposed educational programme that the learners will have a teaching session on reviewing the articles on caring behaviours. Later on, they will have a group discussion for identifying the caring behaviours of nurses and through role play learners will perform the identified caring behaviours and then practise in clinical settings.
- They also commented that reflective writing is a lengthy process and that instead learners going through the whole cycle of reflection they can write one or two paragraphs on positive and negative aspects of caring. Their reflection could be taken as case studies that can be further utilised for the clinical courses for the discussion. The researcher agreed that participants can write one or two paragraphs on the experience of caring and uncaring behaviours and a detailed discussion can be done in the training session. Their case studies can be utilised for discussion in both theoretical and clinical sessions.
- They also commented on the length of the programme, which could be reduced to a one-day due to the work commitments of nurses. Moreover, the delivery options for training could either be face-to-face or for more flexibility and to fit in the time constraints, online. Based on these delivery options and considering the nurses' work commitments, the researcher responded that the length of the programme may not be reduced, however, the four weeks of educational programme will be implemented online. This time period may be sufficient for the learners to experience caring behaviours by themselves. This online educational programme on caring behaviours will be accessible to the nurses at a specific time period (see Table 18). In addition, the idea of training a master trainer (training of nurse managers) for the sustainability of the programme was suggested by the stakeholders. The educational programme for trainers will be conducted face-to-face, in one day. Afterwards they will include this educational programme as part of their on-going continuous sessions to train their nurses. Further details are provided in table 19.

The above section has described the development of an educational programme using the ADDIE model. Within this model, Gagne's instructional design was selected to develop the programme for nurses, based on caring behaviours. This programme was developed using Caring Conceptual Framework from the qualitative interviews in phase

two. The remaining phases of the ADDIE model, development, implementation, and evaluation are covered in the next section.

6.2.5 Further development, implementation, and evaluation

6.2.5.1 Development

After developing the learning objectives and selecting the teaching strategies in the ADDIE phase two, design phase, the development phase of the ADDIE model consists of developing the learning material that will be used during instruction (Cheung, 2016). Taking into account the stakeholders' recommendations, an online educational programme will be developed. The online teaching strategy can be used to design instructional activities that facilitate learners to work independently and achieve learning objectives at their own pace (Abruzzese, 1996; Fitzgerald, 2012). The online educational programme based on the findings from this thesis consists of self-directed activities and group discussion which will facilitate learners learning. This online educational programme will be conducted over a span of four weeks, comprising of six sessions with the total duration of 17 hours. This includes 12 hours of self-directed learning, three hours of group discussion facilitated by the researcher, and two hours of the learners' self-evaluation of their caring behaviours and programme evaluation (see Table 18).

Table 18: Online educational programme

Sessions	Informing the learner of the objectives	Stimulating recall of prerequisite learning	Total learning time (self-directed and group discussion)	Presenting the stimulus material & providing learning guidance	Eliciting the performance (practice)	Assessing performance & providing feedback	Enhancing retention and transfer	Resources
Session 1 Introduction Course objectives Course faculty	Learners will be able to recognise the course, its importance, purpose and learning outcomes Learners will perform pre-test to evaluate their caring behaviours	N/A	Video recording of the introduction (60 min)	Video and on-screen text	N/A	On-text screen instructions regarding filling of caring behaviours questionnaire	N/A	Questionnaire
Session 2 Initiate the session with the images, case scenarios,	Learners will analyse interpret and explain the caring behaviours of	Recall of previous learning	Review images 03 min (each for three images) Total time=9	Insert three Images for brainstorming of caring concepts On-screen text four	Link for the group discussion forum will be generated on Google	Provide feedback on discussion by faculty	Provide learning resources (videos, images, case scenarios)	Images Case scenarios Videos

and videos of caring behaviours	nurses		min Review case scenario 10 min (each for four case studies) Total time= 30 min Watch videos 6 min (each for five videos) Total time =30 min For the group discussion on these learning tools (60 min)	case scenarios Five videos on caring behaviour	Classroom		for the retention of knowledge	
Session 3 Lecture on introduction to caring concepts and related behaviours (see Table	Learners will identify different caring concepts and related caring behaviours.	Same as above	Video recording of lecture (120 min)	Video recording and on- screen power point presentation- PPT	N/A	N/A	Provide learning resources video and PPT Learners practise their	Video of lecture PPT

15). Learners will implement caring behaviours in the clinical practice.							learning in the clinical settings	
Session 4 Introduction to reflective writing	Learners will identify the reflection process. Learners will reflect their caring experiences	Same as above	Video recording of lecture (60 min) Writing reflection (60 min each for three reflections) Total time= 180 min Group discussion (60 min)	Same as above	Link for the discussion forum will be generated on Google Classroom	The learners will submit three reflections Reflection on positive and negative experiences by themselves or by observing their colleagues Provide feedback on reflection by peer and faculty	Learners practise their learning in the clinical settings	Video of lecture PPT

Session 5 Introduction to journal club as a teaching and learning strategy	Learners will be able to: Recognise journal club as a teaching strategy. Identify caring behaviours that nurses have and expectations of the patients. Learner will implement caring behaviours in the clinical practice.	Same as above	Video recording of lecture (60 min) Review the articles (60 min each for three articles) Total time= 180 Group discussion (60 min)	Video recording and on- screen power point presentation- PPT Articles on caring behaviour	Link for the group discussion forum will be generated on Google Classroom	Provide feedback on discussion by faculty	Learners practise their learning in the clinical settings N/A	Video of lecture PPT Articles Video of lecture
Session 6 Post-class Caring behaviours and programme	Learners will perform post-test to evaluate their caring behaviours.	N/A	Fill the questionnaire (60min) Fill the questionnaire (30 min)	Caring behaviours questionnaire Programme evaluation	N/A	Learners will assess their caring behaviour Learners will provide feedback on programme	Same as above	Questionnaires

evaluation	Learners will evaluate the effectiveness of the programme.			questionnaire				

Learners will get frequent feedback on their performance and finish the course in the educational programme of this thesis in a particular time period. This is an alternative to traditional classroom teaching to help nurses to attend the course online for continuous education and professional development when they are not able to get released from the hospital setting due to their work commitments (Fitzgerald, 2012).

Using the experiences of the participants, scripts will be created for videos and case scenarios. All the learning materials will be uploaded on Google classroom and website link will be shared with the learners. Furthermore, a questionnaire to evaluate the effectiveness of the educational programme and measuring the caring behaviours of nurses will also be developed. A questionnaire is a self-administered tool, scale, or instrument that is used to gather information from participants (Groves, 2009). The tool and other learning materials will be validated for its content relevancy and clarity by the same stakeholders that reviewed the proposed educational programme at the design stage. It will also be piloted with nurses and patients to identify the clarity and understanding of the tool, time duration for filling the questionnaire, and if modification is required in the tool.

In addition to online educational programme, training a master trainer (training of nurse managers) for the sustainability of the programme was suggested by the stakeholders. For nurse managers, educational programme will be conducted face-to-face, in one day. This educational programme will have five sessions with the duration of nine hours. Few sessions and teaching, learning, and evaluation strategies were taken from the educational programme developed for nurses (see Appendix J). For instance, lectures on introduction to caring concepts and related behaviours, introduction to reflective writing, and journal club as a teaching and learning strategy. Teaching and learning strategies included, interactive lectures, group discussions on various images, case studies, videos, reviewing the articles and writing a reflection. Evaluation strategies included, explanation and summarisation of the learned knowledge by learners, question and answer sessions, and providing feedback to the learners. At the end of the session, the educational programme will be evaluated through questionnaire survey and focus groups (see Table 19).

Table 19: Educational programme for trainers

Gaining attention	**Informing the learner of the objectives**	**Stimulating recall of prerequisite learning**	**Total learning time**	**Presenting the stimulus material & providing learning guidance**	**Eliciting the performance (practice)**	**Assessing performance & providing feedback**	**Enhancing retention and transfer**	**Resources**
Initiate the session with the images of caring behaviours	**Session 1** Learners will identify different caring concepts and related caring behaviours (see Table 15).	Through questioning (What is your understanding about the caring concepts?) Learners should be encouraged to share their past and current experiences	Images (03 min each for three images) Total time=9 min Interactive lecturing (120 min) Group discussion (30 min)	Reflect on images Interactive lecture	Group discussion	Explanation and summarisation of the learned knowledge by learners Encourage questioning and answering	Provide PPT and other resources for the retention of knowledge	PPT Writing pad with pen Multimedia Survey tool Speakers White board Images

NA	**Session 2** Learners will analyse interpret and explain the caring behaviours of nurses.	N/A	Review case studies 10 min (each for four case scenarios) Total time=30 min Watch videos 6 min (each for five videos) Total time=30 min Group discussion on caring strategies (30 min)	Discussion on learned concept by using different caring teaching strategies: Various case scenarios Watch videos	Critical thinking and decision making through reflection on learning tools	Feedback on discussion	Same as above	Writing pad with pen Multimedia Speakers White board caring Videos Caring scenarios
	Session 3 Introduction to reflective writing Learners will identify the reflection process	Learners will share the past experiences of writing reflections	Lecture (60 min) Write one reflection of their clinical experience (60 min) Group discussion (30 min)	Interactive lecture Group discussion	Write one reflection of their clinical experience	Group discussion on reflection. Review the key points, questions and answering session	Same as above	PPT Writing pad with pen Multimedia Speakers White board
	Session 4 Describe Journal club as a teaching and learning strategy.	Same as above	Lecture (30 min) Review one article (30 min) Group discussion (30 min)	Review the articles Group discussion	Group discussion on the article. Explanation and summarisation of the learned knowledge by	Feedback on discussion	Same as above	PPT Writing pad with pen Multimedia Speakers

	Learners will be able to: Recognise journal club as a teaching strategy Identify caring behaviours that the nurses have and expectations of the patients.				learners			White board caring Article
N/A	**Session 5** Programme evaluation	N/A	Programme evaluation (60min)	N/A	N/A	Feedback on learning Programme evaluation through questionnaire survey and focus groups	Same as above	Survey tools Recorder

6.2.5.2 Implementation

After completing the analysis, design, and development phases, the educational programme can be delivered. The implementation phase is where the newly developed course is delivered in terms of training the participants (Matkovic et al., 2014). The approval for conducting educational programme for nurses would be taken from the institutional review board (IRB) of Shifa Tameer-e-Millat University. However, before implementing on a larger scale, firstly, pilot the project on a small scale to test the feasibility before they are employed on a wider scale (Polit and Beck, 2012). Feedback received from the participants informed further adjustments in the educational programme. For this, a one-day educational programme will be scheduled for few nurses of the medical and surgical departments who provide bedside care or are directly involved in patient care.

6.2.5.2.1 Implementation on a larger scale

The educational programme will be implemented for all nurses working in the medical and surgical departments. The learning objectives, the content of the course, teaching and learning strategies, and evaluation methods will be uploaded on Google classroom. Further details of the online educational programme are in table 18.

6.2.5.3 Evaluation

The learning outcomes will be measured in terms of acquisition of knowledge by assessing the reflection on case studies, images, videos and review of articles. During discussion on different activities, probing questions would be asked for further reflection on caring behaviours. The caring behaviours of nurses will be evaluated pre-and-post educational programme.

6.3 Chapter summary

Phase three was conducted to design an educational programme addressing caring behaviours of nurses based on the Caring Conceptual Framework derived from the findings in phase two. Components of the ADDIE model (analysis and design) were used to design and which was subsequently refined on the advice of the stakeholders. The stakeholders were asked to review the proposed plan of the educational programme and determine its relevancy and practicality. The suggestions were appreciated and the stakeholders' feedback were incorporated in the educational programme.

Chapter 7

Summary and discussion

7.1 Introduction

This chapter discusses the overall thesis and how this work contributes to the existing literature. The aim of the study is presented along with a summary of each phase. The strengths, limitations and findings leading to recommendations, for nursing education, clinical practice and future research are also presented. This chapter ends with the conclusion of the thesis.

7.2 Phases of the study

The aim of this study was to explore the perceptions of patients, nurses, and student nurses regarding nurses' caring behaviours in Pakistan and develop an educational programme to enhance knowledge and understanding of the importance of caring in practice. The key findings from the study's three phases are summarised in the next section.

7.2.1 Mixed-methods systematic review (Phase one, Chapter three)

The mixed-methods systematic review was conducted to synthesise the evidence related to the perceptions of caring behaviour by patients, nurses, and student nurses. Overall, 43 articles were reviewed for this study. The search included studies from 2009 to 2022, which included studies highlighting the importance of physical and expressive care. The participants in the selected studies emphasised that nurses primarily focused on having updated knowledge and skills; being competent in clinical skills; providing comfort for patients by maintaining personal hygiene; administering medication on time and protecting patients from physical and psychological harm. However, the expressive aspect of care was neglected by the nurses. For example, nurses spend quality time with patients; listening to their concerns; treating patients with respect and dignity; building trusting relationships and providing information for patients regarding their health condition and treatment plan.

As shown in chapter three, section 3.2.1, most of the studies reviewed were conducted in different cultural settings, which limits the generalisability of the findings to Pakistan. There were gaps in knowledge specifically regarding perceptions of caring behaviour; concepts of spiritual and cultural care; patient autonomy in decision making and care; counselling and patient advocacy in the Pakistani cultural context. This phase informed the development of the topic guide and study design for phase two.

7.2.2 Qualitative exploratory-descriptive study (Phase two, Chapters four and five)

Semi-structured, in-depth interviews were conducted with 45 participants (17 patients, 15 nurses, 13 student nurses) to explore their perceptions of caring behaviour. Overall, eleven overarching concepts emerged from the analysis of participants' accounts of their perceptions and experiences. One of the most important findings to emerge from this study was that the participants reported positive care experiences with the nurses. However, the study also revealed the psychological distress associated with multiple factors related to hospitalisation and the need to help the patients be self-sufficient in self-care.

A Caring Conceptual Framework with eight caring concepts and themes was developed from the findings in phase two and used to develop an educational programme for nurses. This programme is intended to contribute to the body of knowledge and to improve the understanding and practice of caring behaviours by nurses and student nurses. In the undergraduate nursing programme in Pakistan, currently there is no explicit teaching on caring behaviour. Use of this programme will enable nurse educators to value teaching and developing caring behaviours in nurses of the future.

Nurses faced some challenges such as increased workload, lack of appreciation from the senior nurses, use of technology, difficult behaviour of patients and relatives, and some personal issues, while demonstrating caring behaviour. These challenges lead to ineffective communication by nurses, incomplete nursing procedures of practical, and lack of information being given to patients.

7.2.3 Development of an educational programme (Phase three, Chapter six)

This phase was conducted to develop an educational programme to enhance the knowledge and understanding of the importance of caring in practice. The educational programme was based on the Caring Conceptual Framework derived from the findings in phase two. The programme was developed through the use of the ADDIE model. A comprehensive educational programme was developed and discussed with the stakeholders to identify its relevancy and applicability. They provided some suggestions such as the integration of teaching content of caring behaviour in the course content of 'Fundamentals of Nursing' of undergraduate programme. There were suggestions about using videos based on the caring concepts that can be utilised in the undergraduate and graduate programmes. They also commented on the length of the programme, which could be reduced to a one-day due to the work commitments of the

nurses. Considering the nurses' work commitments, the four weeks of online educational programme will be implemented. In addition, they suggested training nurse managers for the sustainability of the programme in the future. For them, the educational programme will be conducted in one day, face-to-face.

The contributions of the study findings to the literature are discussed in the next section.

7.3 Overall discussion of the thesis

Until recently, there has been no reliable evidence in the Pakistani cultural context that shows the work on the development of an educational programme on caring behaviour. However, one study was conducted in Taiwan to develop an online educational programme on caring behaviour for nurses (Hsu et al., 2014). Brown (2011) suggests introducing three areas with the objectives to be developed in student nurses, for example, cultural diversity, interpersonal relationship and communication. These findings are consistent with the study findings of this thesis; however, current and context based findings were required to meet the needs of the population of Pakistan. For example, in Pakistan, family members are usually responsible for making decisions on behalf of the relative who is in hospital. However, nurses in the current study involved patients to take decisions on the small tasks such as selecting the vein for IV cannulation. Furthermore, in the current study, the patients from both public and private hospitals felt that nurses should ask patients how they would like to be addressed. Patients preferred that a nurse should not address them by their name and rather address them using terms such as 'Sir', 'Baji' or 'Aunty.' In Pakistani culture it seems quite disrespectful when a nurse calls the patient by his or her name. In addition, in the Pakistani culture, most patients prefer care to be given by nurses of the same gender as themselves (Sundus and Younas, 2020).

These few examples illustrate that patients' cultural backgrounds, values, needs, expectations, and preferences may not be consistent with the other cultures. Considering the importance of fulfilling the patient's needs in Pakistan, nurses may require training to improve quality care to the patients.

Currently, nurses in Pakistan are not introduced to the Caring Conceptual Framework. Yet, some of its key concepts are stated in different courses of nursing curriculum. The curriculum mainly focused on self-directed learning, problem solving skills, health promotion and maintenance of the community, different diseases, computer skills and e-learning to keep up with other professionals in terms of technological proficiency (Dias et al., 2010; Bibi et al., 2020). This also accords with the earlier research, which

shows that nursing institutions only emphasise the cognitive and psychomotor aspects of caring (Rinne, 1987; Ellis, 1993; Weis and Schank, 2002; Hsu, 2006). Although these domains are important for clinical practice, student nurses also need to develop their emotions and feelings towards the patients and strengthen expressive care (Brown, 2011). To deal with patients in a humanistic and caring manner, nurses need to possess abilities in developing feelings, attitudes, beliefs and values towards care to the patients (Reilly and Oermann, 1999), that are consistent with the professional values of nursing (Fitzgerald, 2012).

Patients in Pakistan also expect nurses to provide quality care for the patients (Javed and Ilyas, 2018). In order to improve the public's perceptions of nursing and maintain the profession's self-identity (Varaei et al., 2012), it is important that nurses are being educated how to fulfill patient needs. This could be achieved by fostering caring in nursing education (Labrague et al., 2016; Warshawski et al., 2018). The nursing curriculum should encompass caring competencies, emotional and expressive aspects of care, alongside professional knowledge and skills (Mlinar, 2010). A multi-national study identified that student nurses were lacking in these competencies, and this should be emphasised by nursing educators (Huisman-de et al., 2018; Jangland et al., 2018).

Previous studies have demonstrated that emphasis should be placed on teaching student nurses how to be compassionate and caring from the beginning and it should be reinforced throughout their curriculum and the on-going in-service training (Jardien-Baboo et al. 2016). Studies have shown that education can help individuals to develop a more caring attitude towards patients (Wu et al., 2009; Lyneham and Levett-Jones, 2016).

The educational programme from this thesis was based on the Caring Conceptual Framework derived from the findings in phase two (see Chapter five, section 5.2.2). This will help to provide the foundation for the development of caring competences of nurses in Pakistan, which is one of the core values of the nursing profession.

This educational programme aims to provide different teaching strategies for a nurse leader in education and in practice to promote caring behaviour in nurses, such as review of case studies and articles, and writing reflections of their experiences. This would help them to teach quality care and support them to gain knowledge, understanding, and retention of caring skills through different teaching and learning caring experiences. Nurses can improve care delivery in their clinical practice and as a result contribute to positive patient outcomes. Reflecting on caring experiences may illuminate nurse-patient relationships that promote to embrace ethical values, fairness in care delivery and considering patient expectations and rights (Jangland et al., 2022).

This educational programme provides a definition of caring and specific behaviours for Pakistani nurses to implement in the clinical area to meet patient expectations. It is the responsibility of a nurse educator to utilise caring-based teaching strategies and emphasise the importance of caring behaviour in education and clinical practice (Nursalam et al., 2015; Li et al., 2016; Aktas and Karabulut, 2017; Labrague et al., 2017; Tang et al., 2019). If nurse educators inculcate caring behaviour among student nurses, it can improve patient care and bring patient satisfaction. The studies showed a positive relationship between the caring behaviour of nurses and patient satisfaction (Asikin et al., 2020; Kibret et al., 2022).

Based on the suggestions of the stakeholders, the teaching content of caring behaviour will be integrated in the course content of 'Fundamentals of Nursing' of undergraduate nursing programme. Due to the nurses' work commitments, an online educational programme including six sessions over four weeks will be offered for the nurses. So, the nurses attend this course at their own convenience. For the sustainability of the programme, the nurse managers will be trained through one-day workshop.

The next section discusses the strengths and limitations of the study. Documentation of limitations may help the readers to recognise the boundaries and parameters of the study, thus allowing the readers to utilise the findings after considering both the strengths and the limitations of the study (Ritchie and Lewis, 2014).

7.4 Strategies to promote ethical climate

While the development of the educational programme will address knowledge and skills in caring behaviours and hopefully improve nursing practice, as discussed in chapter 1, there are other factors essential to establishing a caring environment.

Because nurses are always committed to improving patient dignity in care, they require more than just education to foster dignity in care. Promoting campaigns for patient dignity helps foster a creative environment where nurses can learn how to uphold patient dignity (Gallagher et al., 2008). The Royal College of Nursing (RCN) dignity campaign in UK was evaluated by Baillie and Gallagher (2010). Their key findings revealed that the nurses' openness and creativity, the organisation's support, as well as their 'leadership and campaign materials', were the primary components that made the dignity campaign possible. The goals of the dignity campaign also emphasised the significance of nurses as role models. An important finding from the RCN survey was how leadership both increased and decreased dignity in care. The important component in promoting patient dignity is the development of educational resources on dignity in care (Baillie et al., 2008; Usberg et al., 2021).

It is the organisation's responsibility to encourage an ethical culture. An ethical environment can be thought of as a shared understanding of how to approach moral dilemmas and what conduct is deemed ethically acceptable by patients and their organisations (Kälvemark et al., 2004). Many participants in healthcare value ethical relationships between nurse and employer. The management should develop an effective and safe environment for the nurses' activities, with the aim of helping to prevent or lessen the nurses' morale issues and negative effects for the patient and the overall healthcare system (Bayat et al., 2019).

If nurses are involved in ethical decision making, they may feel empowered to advocate for patients, moral distress may decrease and consequently lead to an increase in job satisfaction Furthermore, to enhance the ethical environment, relationships with peers, hospital management, patients and physicians should be improved. Managers and peers should advocate for each other in ethically difficult situations (Schluter et al., 2008) and an improved ethical climate might lessen nurses experiencing moral discomfort (Bayat et al., 2019).This may further improve recruitment, retention, organisational commitment (nurses may desire to do best for the organisation) (Goldman and Tabak, 2010), job satisfaction (Borhani et al., 2012), collaboration with physicians (Pauly et al., 2009), and improved patient care (Francine et al., 2013). For example, a study by Storch et al. (2002), explored perceptions of nurses and student nurses of the relationship between ethical practice and moral distress. The participants suggested certain factors to promote ethical practice by nurses, for instance, an organisational ethical climate, availability of essential resources and time (Saberi et al., 2019) and assurance that the ethical concerns would be addressed by the leaders in the organisation.

Ethical conflict may occur due to the mismatch of personal and organisational values. Without enhancing the work environment for moral practice, nurses' understanding of professional ethics may not be improved in a way that resolves their ethical conflict. Nursing professionals may experience less ethical conflict if organisational rules and regulations are developed with their perspectives in mind. Furthermore, developing a reward system for nurses may reduce ethical conflict among nurses, and fostering inter-professional relationships (Saberi et al., 2019). In addition, Varcoe et al. (2012) found that nursing leaders lacked adequate assistance and guidelines from the organisation to secure ethical leadership. Consequently, nurses frequently confronted a lack of ethical leadership to deliver 'safe, compassionate, and ethical care.' Nurses should receive the proper training and organisational support in order to provide high-quality care on a daily basis (Usberg et al., 2021). It is the responsibility of nurse leaders to provide ethical support for nurses. Effective ethical leadership may influence

the ethical climate, which in turn may encourage effective loyalty to the organisation and lower turnover (Varcoe et al., 2012).

Therefore, it is the obligation of the organisation to provide 'physical and psychological safety, justice, and an ethical culture of practice' to the nurses (American Nurses Association, 2015). Nurses build trustworthy psychological relationships with their organisations and trust that the standards for respectful ethical behaviour will be met (Cleary et al., 2018).

7.5 Strengths of the study

This is the first study exploring the perceptions of patients, nurses, and student nurses on the caring behaviour by nurses in Pakistan. The participants were selected from both public and private institutions with different genders, age groups, qualifications, and experiences, which provided in-depth understanding of the phenomenon under study. To ensure the patient voice was heard, some data was collected in the Urdu language, translated and back-translated using a recognised method to ensure accurate meaning of the concepts as expressed by the participants (Chen and Boore, 2009). Framework analysis was used to analyse the data which allowed data analysis in a series of interconnected stages as the method places a higher focus on moving back and forth across the data until a coherent account emerges (Ritchie and Lewis, 2014). To lessen the risk of subjectivity, the researcher and the supervisors were involved in the analysis of study findings to achieve consensus (Andersson et al., 2015).

A qualitative method was on phase two to assess the participants' perceptions of caring behaviours. This allowed them to express their feelings about the phenomenon, and to obtain rich in-depth data which would not have been possible using quantitative methods. The study findings and in particular the evidence based educational programme is novel and envisioned to augment professional development, once refined and evaluated will be transferable and useful in other universities and hospital in-service training throughout Pakistan.

The findings of qualitative exploratory-descriptive studies are not usually designed with the intention of generalisability (Gray et al., 2016). However, having a sufficient sample ensuring that data collection procedures are consistent with the study aim, having a clear data analysis process, and evidence from phase two that recommends a specific educational programme may all contribute to the researcher's credibility (Sandelowski, 2000).

7.6 Limitations of the study

The participants were selected through a purposive sampling strategy, but it is recognised that this may not be a representative sample due to the subjective and non-probability approach for participant (Sharma, 2017). Another potential limitation is the language barrier, as the researcher could include only those participants who could speak Urdu and English, which may have missed engaging with people speaking other languages. The responses of the patients from the private hospital may be biased because they were provided free care services and they may have been hesitant to disclose accurate information fearing that they may not receive care in the future (Rahman et al., 2019). To ensure the trustworthiness of the data, a researcher may involve more than one coder for data analysis (Church et al., 2019). In the current study, analysis of the data was done independently without a co-coder. However, the researcher's supervisors reviewed the analysis process and assisted in identifying the codes, themes, and concepts. The personal judgment and bias of the researchers is also a limitation to be considered (Creswell, 2013), but this was addressed through engaging in reflexivity and by writing a reflective journal as explained in chapter four section 4.2.6.

7.7 Implications for practice

The study findings highlighted several implications to enhance the caring behaviour of the nurses in Pakistan. The implications pertinent to nursing education, clinical practice, and research are detailed below:

In the nursing programme, there is no explicit teaching topic on caring behaviour; however, by including caring concepts and its competency in the nursing curriculum, it is likely to improve the caring behaviours and relationships with patients. This will allow the nurse educators to value teaching and develop caring behaviour in the future nurses.

It is important for the nurses to remain well-informed about caring behaviour to improve patient outcomes. Continuing education for nurses in Pakistan rarely introduces caring competency in nursing. Through in-service training, particularly use of the educational programme developed as part of this thesis, attempts can be made to further nurses' knowledge and skills in caring behaviour. In addition, practice focused policy or guidelines related to caring behaviour need to be developed for the use of experienced, novice, and student nurses to enhance relationships with their patients. This would help to recognise and meet patient needs with the aim of providing quality care.

7.8 Implications for research

The findings suggest that this study may be replicated at the national level in Pakistan to explore the phenomena in more depth. The findings may lead to the development of hypotheses for a quantitative study to evaluate the effectiveness of the educational programme based on the Caring Conceptual Framework and determine the differences in caring behaviour of nurses. Furthermore, to measure the caring behaviour of nurses, a context-based instrument can be developed using the Caring Conceptual Framework proposed in this study.

7.9 Plan for dissemination

Dissemination of the study findings is a key element in implementing knowledge into practice. It is a planned process that considers the intended audience and the context in which research findings will be disseminated for policy development, decision-making, and practical application (Wilson et al., 2010).

According to Edwards (2015), a range of methods can be utilised to disseminate the research findings. The most common are publication of articles in journals and presentations in conferences and seminars. Furthermore, conferences feature leaders who are experts in their field and can put research findings into reality. Researchers can communicate with practitioners through posters, explaining the topics in detail and receive input that will help them with future research. Publications should be in peer-reviewed journals that are indexed by several databases so that others can easily find the required literature. From this thesis, the intention is to publish in a peer-reviewed journal:

- The mixed-methods systematic review from phase one
- The qualitative study exploring perceptions of patients, nurses, and student nurses in phase two

In addition to the two publications, the researcher will disseminate the findings from phase two of the study in conferences. The researcher will also implement the educational programme on the nurse educationalists in Pakistan. This may help a nurse educator to inculcate caring behaviour among student nurses. The researcher plans to also disseminate the findings from the research to the study participants, hospitals and educational institutions where the research took place.

7.10 Conclusion

This study achieved its aim of exploring the perceptions of patients, nurses, and student nurses regarding nurses' caring behaviours in Pakistan and developed an educational programme to enhance knowledge and understanding of the importance of caring in practice which has the potential to improve caring behaviour among nurses in Pakistan.

This educational programme is unique in terms of providing a comprehensive and holistic approach to patient care in the Pakistanis context. This could help the nurses to provide quality care for the patients and improve health outcomes. The teaching content of caring behaviour will be integrated in the course content of 'Fundamentals of Nursing' of undergraduate nursing programme. The online educational programme will be offered for registered nurses. For the sustainability of the programme, nurse managers will be trained through one-day workshop to implement the programme in their institutions, thereby ensuring more widespread use.

The knowledge gained from this study may also help nurse educators develop competency in teaching caring behaviours to students, which, in turn enhances student learning. The data gathered through this study and the educational programme may also be valuable not just for Pakistan, but also for nurses and policymakers globally by contributing to the improvement of nurses' knowledge, and it may change their perceptions of caring behaviours. Finally, this research will provide a foundation for future research and will help to advance professional nursing education in Pakistan.

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Appendices

Appendix A Description of nursing theories

Title	Theorist	Year	Classification	Key features
Environmental Theory	Florence Nightingale	1860	Nursing Philosophy	It is the first nursing theory that focuses on the management of the environment which affects the health of an individual.
Patient – Centered Approaches	Faye Glenn Abdellah	1960	Nursing Conceptual Model	Describes 21 problems of a patient and divided into physical, biological, and socio-psychological needs.
Core, Care, and Cure Model	Lydia Hall	1963	Nursing Conceptual Model	Introduces 3 Cs in the practicing of nursing. Care signifies physical care and providing comfort to a patient. A core is the involvement of health care team members in providing care to the patients. In Cure, the nurse provides care to a patient and a family according to the prescriptions of a physician. She introduces this model for a person who is above the age of 16 and past the acute stage of the illness rather than during the acute stage of illness.
Clinical Nursing – A Helping Art	Ernestine Wiedenbach's	1964	Nursing Conceptual Model	Presents three components of nursing practice: identification of patients need for help, the ministration of help, and validation that the help is given is beneficial.
Self-Care Model	Dorothea Orem’	1971	Nursing Conceptual Model	Presents three interconnected theories: self-care, self-care deficit, and nursing systems. The nursing system is further divided into three categories: wholly compensatory system, partly compensatory system and supportive educative system. This system clarifies nurses and patients about their roles. It is one of the most commonly used in the clinical setting.
Theory of Goal Attainment	King Imogene	1971	Nursing Conceptual Model	Describes the process of the achievement of the goal and the general concept of human behaviour.

System Model	Betty Neuman	1972	Nursing Conceptual Model	There are five variables: physiological, psychological, sociocultural, developmental and spiritual. These variables should be considered while assessing patients reaction to a stressor. A nurse approaches the patients problems at the primary, secondary, and tertiary levels.
Conservation Model (Introduction to Clinical Nursing)	Myra Estrin Levine	1973	Nursing Conceptual Model	Describes the concepts of adaptation, conservation, and integrity. She emphasises nurses to involve in the assessment of an organismic response. An organismic response is a modification in behaviour or variation in the level of functioning in the course of an attempt to adjust to an environment.
An Adaptation Model	Sister Callista Roys	1976	Nursing Conceptual Model	Presents the concept of the human adaptive system and their adaptation level at the time of input of stimuli. The output is the behavioural response that assists as feedback and the coping mechanism is the control process.
The Behavioural System Model for Nursing	Dorothy E. Johnson	1980	Nursing Conceptual Model	A patient is recognised as a behavioural system which encompasses seven subsystems. These subsystems are attachment and affiliation, dependency, elimination, sexuality, ingestion, aggression and achievement.
Theory of Interpersonal Relations	Hildegard Peplau	1952	Grand Theory	Presents three stages while interacting with the patient: orientation, working and termination phase. Nurse seeks information about the patient by doing assessment (history taking through interview), in the orientation phase. In the working phase, the physical care is provided to the patients along with the health teaching and counselling session. The summarisation and closure of the work occur at the termination phase.
Nursing Process Discipline Theory	IDA Jean Orlando	1961	Grand Theory	Introduces an interactive nursing process. This process involves a nurse interacts with the patients in order to identify patient needs and plan the action accordingly. Finally, a nurse also confirms to the patient about the achievement of the goal.
Science of Unitary Human beings	M. Rogers	1970	Grand Theory	Focuses on the human beings as a whole and emphasises about the energy field which is an essential part of the human being and the environment.
Human to Human Relationship Model	Joyee Travelbee	1971	Grand Theory	Describes the phases in order to attain the rapport with a patient: original encounter, in which both the patient and nurse identify to each other. Followed by developing the feelings of empathy and at the later stage, sympathy. At the end,

				accomplishment of the rapport occurs.
Humanistic Nursing	Josephine Paterson and Loretta ZDerad	1976	Grand Theory	Describes the concepts of comfort, empathy, and presence which should be applied in the clinical settings.
Human Becoming (Man-living-health)	Rosemarie Rizzo Parse	1981	Grand Theory	A nurse identifies what is beneficial for the patient, family, and community. However, the authority of the decision making is on the individuals rather than on nurses.
Modeling and Role Modeling	H. Erickson, E. Tomlin, and M. Swain	1983	Grand Theory	Modeling means understanding the point of view of the clients about their condition by using empathy. Role modeling means facilitating a patient towards their health. Role modeling occurs by the planning and implementing care based on the individualised and use of theoretical knowledge.
Health Promotion Model	Nola J. Pender	1982	Grand Theory	Describes about the factors which permits the health promotive behaviour : intellectual or thinking perceptual, the significance of health, perceived regulation of health, self-efficacy, health status, benefits and barriers of health-promoting behaviours and the meaning of health. Modifying factors: demographic and biological features, interpersonal influences and situational and behavioural factors.
Symphonological Bioethical Theory	Gladys husted & James husted	1974	Grand Theory	Symphonology means agreement. This agreement occurs between the healthcare professional and patients. Bioethics means interaction between a patient and a healthcare professional in order to preserve and improve human life. Ethics guides ethical behaviour and standard system to determine and justify action in order to achieve vital and fundamental goals. They introduce a few concepts : Deontology: a person acts according to the current standards and foreseeing the impact of their actions and activities for the benefit of a patient. Utilitarian: a health care provider brings about the maximum benefit for the maximum number of people.

				Emotivism: An action that is based on emotions. Social relativism: they developed a Bioethical Decision Making Model in 2008. In which a person does ethical decision making by considering the context and knowledge of a particular situation.
Transition Theory	Afaf Ibrahim Meleis	2000	Middle- Range Theory	A theorist describes the different types of transitions which a human being faces such as developmental birth, adolescence, menopause, aging and at the last death. There are certain factors that affect the lives of a patient such as: societal, organisational, variation in the environmental condition and working staff. These factors facilitate or hinder achieving a healthy transition. A nurse's responsibility is to assess a client for the readiness and prepares them for the transition.
Maternal Role Attainment – Becoming a Mother	Ramona T. Mercer	1979	Middle- Range Theory	Describes Microsystem which is the immediate environment for the accomplishment of the maternal role: functioning of a family, the relationship of the mother and father, social support, values of a family, stressors within a family, economic status. These variables interact with each other and may affect the role of motherhood. This system emphasises the importance of the role of a father which helps to decrease tension within the mother- infant relationship. Mesosystem which includes: day-care center, school, a setting of work, places of worship within the immediate community setting. Macro system: factors that influence the other two systems; social, cultural, political, and national laws related to the women, children, and health priorities.
Uncertainty in Illness Theory	Merle H. Mishel	1988	Middle- Range Theory	Describes three major themes related to the uncertainty: the antecedent of uncertainty, the process of uncertainty appraisal, and coping with uncertainty. It provides a comprehensive framework for acute and chronic illness including intervention that supports individuals to manage uncertainty and promote optimal adjustment in life.
Self-Transcendence Theory	Pamela G. Reed	1991	Middle- Range Theory	Three concepts have been given by the theorist : Vulnerability means awareness about mortality that arises because of the aging and other stages of life, or in the course of health events and crises of life.

				Self-transcendence: development of self-conceptual boundaries through inwardly reflective experience, outwardly (by understanding others and temporarily (integration of past and future into the present). Wellbeing: A feeling of complete and healthy based on the people's own criteria.
Theory of Illness Trajectory	Carolyn L.Wiener & Marylin J. Dodd	1993	Middle- Range Theory	Describes how patients and families bear uncertainty during the course of their illness and treatment and work strategically to decrease their uncertainty.
Theory of Chronic Sorrow	Georgene Gaskill Eakes, Mary Lermann Burke and Margarate A. Haionsworth	1998	Middle- Range Theory	Describes the coping of a person with chronic illness. Management can be done internally through coping strategies or externally with the interventions provided by the health care practitioner or other persons. Effective management can lead to increased comfort in the affected individual.
The Tidal Model of Mental Health Recovery	Phil Barker	2001	Middle- Range Theory	Introduces the Tidal model that emphasises to understand the need of a person by working collaboratively, developing a therapeutic relationship through active empowerment, performing interdisciplinary intervention in order to resolve problems and promote mental health. This model describes the ten principles or the commitments for the practitioner to follow.
Theory of Comfort	Katharine Kolcaba	1996	Middle- Range Theory	Emphasises to providing comfort at the time of stress. When comfort is enhanced, it provides strength to the patients and families for the performance of the task. Comfort can occur physically, psychologically, spiritually, environmentally, and socially.
Postpartum Depression Theory	Cheryl Tatano Beck	1978	Middle- Range Theory	Describes Post-Partum Depression and Maternity Blues which begin as 4 weeks after the birth of a baby.
Peaceful End of Life Theory	Cornelia M. Ruland & Shirley M. Moore	1998	Middle- Range Theory	Describes the care of the terminally ill patient and their family members. Nursing intervention should be designed to free a patient from pain, providing comfort, dignity, respect, and peace.

Appendix B Spider search strategy

Question:

1. What are the perceptions of the adult patients regarding caring behaviour of nurses admitted in the hospital?

S- **Sample**: adult, inpatient, acute care setting, hospitalisation, medical-surgical

P of I – **Phenomenon of Interest**: caring behaviour, compassion, compassionate care, attitude, hospital care, empathy, patient's experience, patient's satisfaction

D-**Design**: questionnaire, interview, focus group, observation

E- **Evaluation**: perception, patient's perception, view, experience, perspective

R- **Research type**: qualitative, quantitative, mixed methods

Search strategy:

Individual and combined the terms with the Boolean operators (AND, OR and NOT)

Limits applied to the search:

Age: young to older adult

Year(s) of publication: 2009-2022

Language: English

List of the databases:

Medline, PsycINFO, Embase, CINAHL, Scopus and Web of Science

Question:

What are the perceptions of nurses regarding caring behaviour working in the hospital?

S- **Sample**: nurse, inpatient, acute care setting, hospital, medical- surgical

P of I – **Phenomenon of Interest**: caring behaviour, compassion, compassionate care, attitude, hospital care, empathy, attitude of health personnel

D-**Design**: questionnaire, interview, focus group, observation

E- **Evaluation**: perception, nurses perception, view, experience, perspective

R- **Research type**: qualitative, quantitative, mixed method

Search strategy:

Individual and combined the terms with the Boolean operators (AND, OR and NOT)

Limits applied to the search:

Year(s) of publication: 2009-2022

Language: English

List the database:

Medline, PsycINFO, Embase, CINAHL, Scopus and Web of Science

Question:

1. What are the perceptions of student nurses regarding caring behaviour?

S- **Sample**: student nurses, inpatient, medical-surgical. Acute, setting, health care

P of I – **Phenomenon of Interest**: caring behaviour, compassion, compassionate care, attitude, hospital care, empathy, experience,

D-**Design**: questionnaire, interview, focus group, case study, observation

E- **Evaluation**: perception, view, experience, perspective

R- **Research type**: qualitative, quantitative, mixed method

Search strategy:

Individual and combined the terms with the Boolean operators (AND, OR and NOT)

Limits applied to search:

Year(s) of publication: 2009-2022

Language: English

List of the database

Medline, PsycINFO, Embase, CINAHL, Scopus and Web of Science

Appendix C Search strategy

1 (nurse* adj (view* or opinion* or attitude* or concern* or belief* or feeling* or idea* or perce* or perspective* or esxpectation* or preference* or need* or satisfaction)).tw. (10555)

2 "attitude of health personnel"/ (52329)

3 caregivers/ [psychology] (51878)

4 or/1-3 [nurses perception] (111635)

5 empathy/ (21901)

6 empathy.tw. (12990)

7 compassion*.tw. (11764)

8 kindness.tw. (976)

9 (caring adj5 behavio?r*).tw. (695)

10 or/5-9 [caring behaviour] (35413)

11 4 and 10 [nurses perception and caring behaviour] (2934)

12 (acute adj (setting* or hospital* or care or healthcare)).tw. (36532)

13 hospital care.tw. (9978)

14 exp hospitals/ (956307)

15 hospitalization/ (330763)

16 (hospitali?ation or hospitali?ed).tw. (304358)

17 Inpatients/ (126925)

18 inpatient*.tw. (151792)

19 medical surgical.tw. (7866)

20 or/12-19 [hospital] (1455076)

21 11 and 20 [nurses perception and caring behaviour and hospitals] (406)

22 limit 21 to (english language and yr="2009 - 2022") (204)

23 ((patient* or user*) adj3 (view* or opinion* or attitude* or concern* or belief* or feeling* or idea* or perce* or perspective* or experience* or expectation* or preference*OR need* or satisfaction or interaction*)).tw. (462588)

24 exp patient satisfaction/ (127244)

25 patients/ [psychology] (1042995)

26 or/23-25 [patient experience] (1503810)

27 empathy/ (21901)

28 empathy.tw. (12990)

29 compassion*.tw. (11764)

30 kindness.tw. (976)

31 (caring adj5 behavio?r*).tw. (695)

32 or/27-31 [caring behaviour] (35413)

33 26 and 32 [patient experience and caring behaviour] (5655)

34 (acute adj (setting* or hospital* or care or healthcare)).tw. (36532)

35 hospital care.tw. (9978)

36 exp hospitals/ (956307)

37 hospitalization/ (330763)

38 (hospitali?ation or hospitali?ed).tw. (304358)

39 Inpatients/ (126925)

40 inpatient*.tw. (151792)

41 medical surgical.tw. (7866)

42 or/34-41 [hospital] (1455076)

43 33 and 42 [patient perception and caring behaviour and hospitals] (1232)

44 limit 43 to (english language and yr="2009 - 2022") (1008)

45 (student nurse* adj3 (view* or opinion* or attitude* or concern* or belief* or feeling* or idea* or perce* or perspective* or experience* or expectation* or preference* or need* or satisfaction)).tw. (610)

46 "attitude of health personnel"/ (52329)

47 caregivers/ [psychology] (65200)

48 or/45-47 [nursing students perception] (117106)

49 empathy/ (21901)

50 empathy.tw. (12990)

51 compassion*.tw. (11764)

52 kindness.tw. (976)

53 (caring adj5 behavio?r*).tw. (695)

54 or/49-53 [caring behaviour] (35413)

55 48 and 54 [nursing student perception and caring behaviour] (2890)

56 (acute adj (setting* or hospital* or care or healthcare)).tw. (36532)

57 hospital care.tw. (9978)

58 exp hospitals/ (956307)

59 hospitalization/ (330763)

60 (hospitali?ation or hospitali?ed).tw. (304358)

61 Inpatients/ (126925)

62 inpatient*.tw. (151792)

63 medical surgical.tw. (7866)

64 or/56-63 [hospital] (1455076)

65 55 and 64 [nursing student perception and caring behaviour and hospitals] (391)

66 limit 65 to (english language and yr="2009 - 2022") (197)

Appendix D Assessment of methodological quality

	Screening questions (for all types)		Qualitative				
Author/ Year / Country	**Are there clear research questions?**	**Do the collected data allow to address the research questions?**	**Is the qualitative approach appropriate to answer the research question?**	**Are the qualitative data collection methods adequate to address the research question?**	**Are the findings adequately derived from the data?**	**Is the interpretation of results sufficiently substantiated by data?**	**Is there coherence between qualitative data sources, collection, analysis and interpretation?**
(Dobrowolska and Palese, 2016)/ Eastern Region of Poland	Y	Y	Y	Y	Y	Y	Y
(Ambrosi et al., 2021)/Italy	Y	Y	Y	Y	Y	Y	Y
(Petrou et al., 2017)/ Cyprus-Italy	Y	Y	Y	Y	Y	Y	Y
(Jill et al., 2015)/United Kingdom	Y	Y	Y	Y	Y	Y	Y
(Kalfoss et al., 2017)/Oslo	Y	Y	Y	Y	Y	Y	Y
(Canzan et al., 2014)/Italy	Y	Y	Y	Y	Y	Y	Y
(Modic et al., 2014)/Midwest	Y	Y	Y	Y	Y	Y	Y
(Coughlin, 2013)/United States(Northeast)	Y	Y	Y	Y	Y	Y	Y

(Rahman et al., 2019)/Pakistan	Y	Y	Study design was not mentioned. However, a deductive approach was used to analyse the data	Y	Y	Y	Y
(Marshall et al., 2012)/South Australia	Y	Y	Y	Y	Y	Y	Y
(Mako et al., 2016)/Sweden (South)	Y	Y	Y	Y	Y	Y	Y
(Esmaeili et al., 2016)/Tehran	Y	Y	Y	Y	Y	Y	Y
(Sundus and Younas, 2020)/Pakistan	Y	Y	Y	Y	Y	Y	Y
(Andersson et al., 2015)/Sweden	Y	Y	Y	Y	Y	Y	Y
(Tsai and Wang, 2015)/Taiwan (Southern)	Y	Y	Y	Y	Y	Y	Y
(Cheruiyot and Brysiewicz, 2019)/ South Africa	Y	Y	Y	Y	Y	Y	Y
(Jardien-Baboo et al., 2016)/South Africa	Y	Y	Y	Y	Y	Y	Y
(Costello,	Y	Y	Y	Y	Y	Y	Y

2017)/Boston							
(Pearcey, 2010a)/United Kingdom	Y	Y	Y	Y	Y	Y	Y
Quantitative	**Are there clear research questions?**	**Do the collected data allow to address the research questions?**	**Is the sampling strategy relevant to address the research question?**	**Is the sample representative of the target population?**	**Are the measurements appropriate?**	**Is the risk of nonresponse bias low**	**Is the statistical analysis appropriate to answer the research question?**
(Fang et al., 2020)/ East Coast of China	Y	Y	All the nurses were selected	Y	Y	78.5% response rate	Y
(Fenizia et al., 2020)/Italy	Y	Y	All undergraduate student nurses	May be representative with 03 sample size, research conducted at two Italian universities	Y	Not mentioned	Y
(Allari et al., 2022)/Middle east (Jordan, Palestine, Saudi Arabia, the United Arab Emirates, Oman and Egypt)	Y	Y	Second-third- and fourth-year student nurses /Convenience	Y	Y	Not mentioned	Y

(Akansel et al., 2021)/Turkey	Y	Y	Sampling strategy was not mentioned	Y	Y	92.8 % response rate	Y
(Ferri et al., 2020)/Italy	Y	Y	All students were selected	Y	Y	89.2% response rate	Y
(Labrague, 2012)/ Catbalogan City, Philippines	Y	Y	Purposive Sampling	Y	Pretesting and reliability and validity of the tool were not mentioned	Response rate was not mentioned	**Y**
(Zamanzadeh et al., 2014)/ Tabriz and Urmia faculties of nursing	Y	Y	Convenience sampling was done	Y	Questions were not pretested prior for the data collection/ reliability and validity of the tool were not mentioned	Response rate was not mentioned	**Y**
(Mlinar, 2010)/Slovenian	Y	Y	Collected the data from all the student nurses	Y	Questions were not pretested prior for the data collection. However, validity/ reliability were mentioned from the previous	Mentioned about the response rate, 76.6% with no justification mentioned	Y

					literature		
(Labrague. et al., 2017)/Philippines Greece, Nigeria, India	Y	Y	Convenience sampling was done	Y	Y	500 students were invited to participate in the study and 467 responded (93.4%)	Y
(Aktas and Karabulut, 2017)/Turkey	Y	Y	All the student nurses were selected	Y	Reliability and validity, pretesting of the tool were not mentioned	Didn't discuss about the response rate that might affect the analysis of the result	Y
(Trinidad et al., 2019)/Universidad Europea de Madrid	Y	Y	All the student nurses were selected	Y	Determined validity and reliability from the previous study	Not mentioned about the low response rate	Y
(Li et al., 2016)/Taiwan	Y	Y	Y	Y	Y	Y	Y
(He et al., 2013)/China (Central, Southern, and Eastern)	Y	Y	Convenience sampling was done	Y	Y	The study didn't discuss about the response rate that might affect the result	Y
(Aupia et al., 2018)/Indonesia	Y	Y	Sampling strategy was not mentioned	Y	Y	Y	Y
(Papastavrou et al., 2012) /Six different European countries (Finland , Greece Cyprus, Czech Republic	Y	Y	Convenience sampling was done	Y	Y	The study didn't discuss about the response rate that might affect the result	Y

Hungary, Italy)							
(Flynn, 2016)/UK	Y	Y	Probability Stratified sampling method was used.	Y	Y	Didn't discuss about the response rate that might affect the result. However, it was mentioned that 100 questionnaires were distributed, 50 each to the participants and researcher received 57 completed questionnaires	Y
(Omari et al., 2013)/ Jordan	Y	Y	Convenience	Y	Y	Didn't discuss about the response rate that might affect the result	Y
(Kiliç and Öztunç, 2015)/Turkey	Y	Y	All patients and nurses	Y	Y	Didn't discuss about the response rate that might affect the result	Y
(Roulin et al., 2020)/Geneva, Switzerland	Y	Y	Convenience sampling was done	Y	Cronbach alpha coefficient varies between .92 and .95 from the previous study. However, validity was not	Patients (85%) response rate The main reason of drop out was fatigue	Y

					done and reliability .90 was mentioned.		
(Edvardsson et al., 2017)/Australia	Y	Y	Consecutive sampling strategy was used	Y	Not mentioned about the validity and reliability of the tool. Pilot testing of the tool was not done	Didn't discuss about the response rate that might affect the result	Y
(Merrill et al., 2012)/ghana	Y	Y	Convenience sampling was done.	Y	Questionnaire was not pretested prior to the data collection. However the validity/ reliability were mentioned	Didn't discuss about the response rate that might affect the result	Y
(Afaya et al., 2017)/Ghana	Y	Y	Probability Systematic sampling was done	Y	Not mentioned about the validity and reliability of the tool. Pilot testing of the tool was not done	A total of 200 questionnaires were distributed, out of that, a total of 183 questionnaires were recovered and considered for the analysis Response rate 91.5%.	
(Youssef et al., 2013) /Taif City	Y	Y	Convenience sampling was used	Y	Y	Didn't discuss about the response rate that might affect the result	Y

Mixed Methods (Triangulation)	**Are there clear research questions?**	**Do the collected data allow to address the research questions?**	**Is there an adequate rationale for using a mixed methods design to address the research question?**	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
(Thomas et al., 2019)	Y	Y	Rational of choosing mixed methods design was not shared	Interrelation of quantitative and qualitative studies to form a complete picture	Meta-inferences done by interpreting qualitative and quantitative findings	Discrepancies in the findings were explained	Validity of the tool was not measured Reliability Cronbach alpha .89 and .93 for the first and second survey Rationale for choosing Mixed-Methods design was not mentioned. Rationale for exclusion of participants was not mentioned Non probability sampling techniques (Convenient) was used which does not represent the target

							population The tool is justified and appropriate for answering the research question Conceptual definition of each variable was not mentioned. Any drop out/ withdrawal of the participants was not mentioned Confounding variables can distort the interpretation of findings. However, this study didn't mention about the confounding bias.

Appendix E Data extraction

Author/Country	Aim	Design	Setting/Sample/Sampling/Data Collection	Finding	Limitation
(Dobrowolska and Palese, 2016)/ Eastern Region of Poland	Student nurses perception about caring, its features and possible hurdles	Qualitative content analysis	Nursing Institution/(n=15) Polish Students of three years degree programme/ Purposive/ Narrations has been written by the first year nursing students before and after their clinical experience./ Text-diaries	Expressive caring was more valued and appreciated by the student nurse than the instrumental caring. "caring comes from within the individual reflecting an internal human need, as the desire to do good" "Caring means going towards the extra miles" Helping patients to perform basic daily activities such as feeding, bathing, toileting. Administration of medication on time, "changing patients' position, offer things such as blanket, keep the things within reach of the patients, providing backrub, making the	The two different time periods have been selected for the data collection. This might affect the behaviours of the participants because of the theoretical and clinical exposure. Narrations have been collected by the faculty members which might be biased the results. Findings of the study can't be transferable because it has been conducted in one University.

				surrounding neat and clean before leaving the room” “Protecting patients from physical harm such as fall , ulcers, malnutrition” Monitor the patients for their well being Spending time with patients, listening to them “Promoting patients independence by allowing them to make independent decision” Caring for the spiritual needs of patients **Constraint** He/she can have family problems or simply lack knowledge on providing good care (mostly preclinical students).” “Expectation of being appreciated, “she is caring but sometimes the patient is ungrateful” “Nurses do not know when they should stop caring and let the patient become	

				independent, prepared for self-care” “Lack of time; too many patients and too many duties, tiredness; lack of independence at work; and lack of a satisfying remuneration.”	
(Ambrosi et al., 2021)/Italy	To explore perception regarding caring behaviour among student nurses.	Qualitative longitudinal design	Student nurses (II and III year) (n=24)/convenience/semi-structured interviews and observation	Student nurses and staff nurses reassured the patients by touching them Empathetic behaviour towards patients Establishing trusting relationships with the patients was considered by all three- year students Students in the second and third years of the nursing programme realised helping patients through continuity of care. Students defined competency means correctly performing the skills in the first year. In contrast, in second and the third year, mastery of	Study cannot be transferable because it has been conducted in one University.

				clinical skills and providing evidence-based practice was enhanced. Keeping emotional distance from the patient was a concern for first-year nursing students. They perceived nurse can build a bond with their patient without becoming too attached to them. This may risk of creating a strong friendly relationship that may affect their 'professional authority' necessary to 'maintain the nurse-patient relationship' Students in their first year thought they had more time to spend with the patient. The students in the second and third years understood the significance of this action but also the need to give each patient 'the right time,' which doesn't mean giving everyone the same amount of time	

				but rather giving each patient the individualised amount of time they require and attending to all of their needs in a way that makes the patient feel at ease and at peace.	
(Petrou et al., 2017)/ Cyprus-Italy	Student nurses perception of caring	Qualitative approach	Nursing Department of a Cypriot University. Students (n=122) Questionnaires (open ended)	Helping patients to perform basic daily activities such as feeding, bathing, toileting. Hold the patients' hand and touch their arm and forehead for providing psychological support	Study conducted in one institution, findings may not be transferable.
(Phillips et al., 2015)/United Kingdom	Student nurses beliefs and values about caring at the initiation of the nursing programme	Longitudinal qualitative study	Nursing Institution/ (n=36) Undergraduate pre-registration nursing students from the two discrete programmes (Advanced Diploma and BSc (Honours)/ Purposive/Semi-structured interviews	"Pharmacological intervention, medication and non-pharmacological actions 'touching' and 'changing the patient's position' to relieve symptoms"	Lack of description about the rigour/ or trust worthiness of the study findings.
(Kalfoss and Owe, 2017)/Oslo	Explored concept of professional care from student nurses	Exploratory qualitative study/ The theoretical framework was based on Watson's Human Caring	Nursing Institution/(n=31) Post bachelor students in Cancer Nursing, Nephrology Nursing, Pastoral Counselling, Public Health Nursing, and Masters' students in Community Health Nursing /Purposive/ Focus group	Respect for the uniqueness of the patients Patients could keep a sense of autonomy and self-respect by being encouraged to	Collection of the data from a single setting. The findings may not be transferable to the target

			discussion	make decisions. However, nurses cannot accept their decision when it causes risk or danger to their quality of life and health Seeing for the whole person and not disease. One sees the human being in the patient Caring means working in collaboration and delegating the responsibility to colleagues. This could make things go more smoothly. Maintain confidentiality “Not using empty words like stating “everything will be okay”, and not giving false hope.”	population.
(Canzan et al., 2014)/Italy	Comparison of the perceptions of caring from nurses and patients	Qualitative descriptive study	Hospital setting (gerontological department/(n=40) (20) nurses and (20) patients/Purposive/ Semi-structured interview	Invisible caring Reflection and critical thinking of patients problems Nurses need to be competent by using their clinical skills in reducing risks to the	The trust worthiness of the data was not mentioned.

				patients and preventing them from an emergency situations by recognising the signs and symptoms of an emergency situation "nurse who remembered his/her need and kept a promise: "When the nurses tell you 'I "Patients appreciated nurses who had positive attitudes and were cheerful, with them" Patients has right to make independent decision "The continuous provision of clear information was valued by patients because it allowed them to participate in decision-making.	
(Modic et al., 2014)/Midwest	Diabetic patients and nurses perceptions of caring behaviour	Qualitative descriptive study/survey	Acute care setting/(n=118) (64) Nurses and (54) patients with diabetes/ Convenience/Survey/ open ended question.	Nurses stated that she listened to the patients when they were not cleared about the prescribed medication or its dosage. "Thirty-four patients	Trust worthiness of the data was not mentioned.

				(62%) stated, nurses providing information about their blood sugar results and informed of upcoming tests and procedures” The six (11%) patients who experienced hypoglycemia received prompt care from nurses Teaching was the most prevalent caring behaviour identified by 41 (76%) of nurses.	
(Coughlin, 2013)/ United States (Northeast)	Perceptions of nurses and patients about care during key events of the hospitalisation (admission, transfer to the operation room and preparation for discharge	Ethnographic methodology	Hospital setting/(n=12) (10) patients and (2) nurses/sampling strategy not mentioned/Participant observation and unstructured interview	Laughing and talking with them patients were uncomfortable by having hard bed, noise, and tasteless food. Whereas nurses perceived, pillows were not in good condition, ward was noisy at night due to noisy equipment, food was not appropriate for cardiac patients Patients in the surgical unit observed nurses responded late and they expected response time should be improved	A very small number of sample and the participants from one setting, the findings may not be transferable to the target population.

				It was observed by the researcher that the patient seldom required to use their call bells because nurse anticipated their needs on time	
(Rahman et al., 2019)/Pakistan 2019	Health care providers and patients. Perceptions regarding best practices in patient-centred care (PCC). Identified the similarities of perspectives between both the groups	Qualitative descriptive study	Tertiary care hospital (Orthopaedic Department)/ (n=36) (18) Health care providers (nurses, consultant doctors, Residents, radiologists, and physiotherapists) and (18) patients/Purposive sampling/ six focus group interviews (FGIs)	Patients and nurses agreed that empathetic behaviour promotes a collaborative relationship with them. Both groups agreed that providers spend time to counsel their patient and relieved their doubts and fears. In decision making, family involvement was also an important factor for patients.	Patients were getting free-of-cost services from the hospital, responses may be biased because of this facility. Results from the private sector may not be transferable to the public sector.
(Marshall et al., 2012)/ South Australia	Understanding of patients about patient-centred care and identified the relationship of it with the existing literature.	Qualitative phenomenologic	Metropolitan Hospital (surgical unit)/(n=10) Patients/Purposive/ Interpersonal interviews	Nurses ensured to come on time when they called them and fulfil their needs The use of humour by staff nurses as a coping mechanism to fulfill emotional needs of their patients. According patient making jokes about various topics can	Trust worthiness of the data was missed. One single department and site may affect the transferability

				help them stay positive and divert their mind The patients in surgical unit complained about the tasteless food and variation in room temperature Participants identified the need to see other patients and do paperwork as major barriers to the staff providing the best care they could Despite their lack of medical knowledge, they are nonetheless experts in their illnesses. They should be regarded and respected rather than just a “number	
(Mako et al., 2016)/Sweden (South)	Patients’ meaning of good care	Constructivist grounded theory	Surgical department/ (n=13) patients/ Theoretical/ Face to face interview	Ensure patients feel safe Reducing patient’s anxiety while performing invasive procedure Act of listening to people Patients has right to make independent	A small number of participants, transferability is questionable.

				decision	
(Esmaeili et al., 2016)/Tehran	Cardiac patients perceptions of patient-centred care	Descriptive qualitative study	Cardiac Unit/(n=18) cardiac patients/ Purposive/Semi-structured interviews	"Protecting patients from physical harm (fall , ulcers, malnutrition)" Patients who experience poor communication feel disregarded and neglected. They believed that treating patients with respect in the beginning and throughout their hospitalisation gives them a great deal of confidence and comfort in the stressful environment. Patients expected nurses to just greet them with a smile. Patient believed that making decisions without taking patients' opinions into account, it showed disrespecting or ignoring patients' expectations	A small number of participants, transferability is questionable
(Andersson et al., 2015)/Sweden	Registered nurses perceptions about the caring concept	Qualitative design phenomenog raphic	Coronary Care Unit /(n=16) Nurse/Purposive/ Interview	Nurses checked the vital signs and promptly recognised the changes in the health condition of the	A small number of participants, transferability is questionable

				patients Evaluating the effects of different types of treatment	
(Tsai and Wang, 2015)/Taiwan (Southern)	Perceptions of registered nurses about the caring behaviour	Qualitative study	Hospital setting/(n=58) Nurse/Convenience sampling/Semi-structured interview	"Providing physical comfort patient felt higher satisfaction" Reduce patients' anxiety while performing invasive procedure Possessing the practical competences is required to perform the procedure correctly. This behaviour may ensure the patients that they are safe and prevent them from physical pain or anxiety.	Trust worthiness of the data and the pilot testing of the interview guide was not mentioned. Involved one hospital and the participants were only females, the study findings may not be transferable.
(Cheruiyot and Brysiewicz, 2019)/South Africa	Perceptions of caring and uncaring nursing encounters	Qualitative descriptive stud	Inpatient (Rehabilitation setting)/(n=21) Nurses/Purposive/Semi-structured individual interview	"going the extra mile," **Uncaring behaviour** Patients from the rehabilitation department might occasionally be demanding, annoying, and irritated nurses. Patients were aggressive with nurses as well, shouting at them. The nurse thought the	Limitation of the findings to be transferable to the culturally diverse patients from rehabilitative department.

				patient did not like her. This affected her to demonstrate caring behaviour Nurses were not doing enough to safeguard the patients and keep them safe. When nurses failed to promote patient safety, they were unhappy. Nurse claimed that they did not ignore the patients consciously. They might busy with other patient. Motivating the patients to keep a fighting spirit, they assisted the patients in coping with their impairments and overcoming the difficulties. By consistently reassuring the patients that they were making adequate progress even when they weren't, they created and maintained hope in their lives.	
(Jardien-Baboo et al., 2016)/South	Perceptions about patient-centred care	Qualitative descriptive	Public hospital(n=40) Nurses/Purposive/ semi-	Their perception that the patient should be	A study has been conducted in the public

Africa	from the professional. Enabling and inhibiting factors to patient centered care.		structured interviews	seen as a human being with various components such as psychological, physical, social, emotional and spiritual aspects which impact on an individual's health was evident. **Obstacle patient-centered care:** 'a lack of adequate resources', 'increased administrative work' Caring behaviour Gestures such as smiling and the manner in which a patient is addressed The tone which the nurse uses should be respectful and not loud **Enabling environment** Both nurses and nurse managers emphasised the importance of positive working environment. The need for continuous in-service education and training	hospitals. Findings could not be transferable to private hospitals.

				on different topics was mentioned by all the participants **Resources** Participants voiced their frustrations with regard to the non-appointment of staff in the face of staff shortages, the resultant increased workload, as well as limited equipment, Displays a lack of nursing ethos. The harsh manner in which some nurses communicate with patients causes patients to feel upset and afraid and ultimately, they are less likely to communicate their needs	
(Costello, 2017)/Boston	Identified the characteristics and behaviours from nurses who were identified by the patient as a best nurses	Qualitative Study	Medical Surgical unit/(n=9) nurses/Sampling not mentioned/ Focus group	Caring for the spiritual needs of patients "knowing the patient" is important. They emphasised the significance of truly being present for patients rather than simply rushing in to	Trust worthiness of the data was not mentioned

				finish tasks. "Nurses described praying with patients of faiths different than their own because they believed that this would make the patients feel better." Patients whose religious beliefs differ from the nurses received spiritual support from them. They prayed with patients who practised other religions because they thought that would help the patients to feel better	
(Pearcey, 2010)/United kingdom	Opinion of qualified nurses about the central values in clinical nursing	Grounded theory approach/	Hospital setting (n=25) qualified nurses/Sampling not mentioned/Semi structured interviews	This was particularly obvious when some interviewees indicated they were busy doing physical care but had no time for emotional care. The majority thought students need to see caring behaviour in the clinical area but also held the view that it was something innate that the students needed to bring with them.	Trust worthiness of the data was not mentioned

(Sundus and Younas, 2020)/ Pakistan	Patients perspective of caring behaviours of male nurses	Descriptive qualitative study drawn from a larger convergent mixed-methods	14 Medical Surgical Departments of three private hospitals in Islamabad, Pakistan/ Semi-structured interviews/ purposive/ Patients (n= 15)	“Strong knowledge about different conditions of patients with different diseases” Nurses advocating on his/her behalf to the rest of the team Apologising for late response to call for care	Broader transferability of the findings is limited because of the secondary data from the previous study.
(Fang et al., 2020)/ East Coast of China	To explore perceptions of caring based on ‘CARE model’ from nurses. To provide practical guidelines for nurses to improve their behaviour.	Cross-sectional survey	Nurses working in the following units of the internal medicine department, Endocrinology, Respiratory, Cardiology, Gastroenterology, Pain, Neurology, Nephrology, Oncology, and Hematology/ (n=157) four dimensions of CARE Model	Competence (68.79%), Altruism (73.25%), Responsibility (86.62%), Empathy (81.53%). Narrative response “hands-on ability Nurses need to work efficiently and provide safe and accurate care and avoid medical error Nurses believed helping the other colleagues in the unit within their capacity to help patients is important	Study conducted in one university, results may not be transferable.
(Akansel et al., 2021)/Turkey	To investigate nurses perception on caring activities	Descriptive study design	Nurses working in one university hospital/ (n=260)/25-item- Caring Dimensions Inventory	Explain the clinical procedure to the patient. Observe the effects of medication.	Study conducted in one University, results may not

				Patients have a right to be treated in accordance with their cultural beliefs. Involving patients in their care should be considered as important caring activities in nursing. However, in this study, these behaviour was least consider by nurses due to high patients' ratio.	be generalised.
(Allari et al., 2022)/ Middle East	To explore and compare perception of undergraduate student nurses about caring	Cross-sectional-descriptive, comparative design	Nursing students (n= 1,582)/ convenience/Caring Dimensions Inventory	Nurses considered privacy for a patient (M=4.86 SD=0.519) Students checked the vital signs and promptly recognised the changes in the health condition of the patients (M = 4.79, SD = 0.61)	use of self-report surveys, which might have caused participants to give socially acceptable answers. The study's generalisability was further restricted by the use of networking and snowball sampling.
(Fenizia et al., 2020)/ Italy	Analyse the variations in caring behaviour among student nurses during	Descriptive longitudinal study	Undergraduate student nurse (II and III year) (n=103)/ Italian Caring Behaviors Inventory questionnaire	Doing the task competently was also considered by second- and third- year students Second- and third-	Sample size should have been increased Participants should have been selected

	the academic year.			year students perceived least consider in responding to patients individual needs	from more universities
(Labrague, 2012)/ Catbalogan City, Philippines	Perception of patients towards caring competencies of Level IV students	Descriptive research	Different clinical units of Samar Provincial Hospital/ (n= 174 patients)/Purposive Sampling/CBA -63 Caring Behaviour Assessment Tool	Highest rated by patients in “Knowledge and skills ”subscale ‘Know how to give shots, IVs’, “Respectful” ‘Kind and considerate’, “Assurance” ‘Give me treatments and medications on time; and least rated in “Assurance”, ‘Talk to me about my life outside the hospital’, “Trusting relationship” ‘Ask me what I like to be called’, ‘Introduce themselves to me “Teaching and learning“ ‘Tell me what to expect during the day’	Response rate, representation of the sample, pretesting and reliability and validity of the tool were not mentioned.
(Zamanzadeh et al., 2014)/Tabriz and Urmia faculties of nursing	Perceptions of student nurses toward caring behaviour	Cross-sectional	Nursing School/ (n=230) All first and fourth-year nursing students/ Convenience sampling/Larson's Caring Questionnaire Caring Assessment Questionnaire (Care-Q)	Both groups rated higher score in the Subscale “monitors and follows through" “ to demonstrate professional competency and be	Representation of the sample and validity reliability of the tool were not mentioned

				assured that nursing actions delegated to others were completed (e.g., to know when to call the doctor, etc.)” “to give a quick response to the patients' call” and rated lower score in "anticipates" “to anticipate the changes in patient’s situation and take anticipatory actions (e.g., is perceptive of the patients' needs and plans or acts accordingly, etc.)”and "trusting relationships" “to convey a sense of commitment and understanding to patients (e.g., when with a patient, to concentrate only on that one patient, etc.)” Fourth year students rated higher than the first-year in subscale "explains and facilitates teaching, “clarifying, and advocating (e.g., to teach the patient how to care himself/herself whenever possible, etc.)"	

(Ferri et al., 2020)/ Italy	Perceptions of caring behaviour by student nurses	Three-cohort observational study	Nursing School/(n=331) All the students selected / CBI-24	"Responding to individual needs" and "Being with" highest rated among the first year students. At the end of the first year, students were able to demonstrate expressive care. Instrumental care developed in the second and third year. Students encouraging patients to call them in case of problems (5.30 (0.8), 5.52 (0.9), and 5.70 (0.7, respectively) and responding them promptly (4.80 (0.9), 5.05 (1.0), and 5.28 (0.8, respectively).	Study conducted in one University, results may not be generalised.
(Mlinar, 2010)/Slovenian Rou	Identification of the significant differences in the mean scores among the first-year and third-year student nurses.	Survey design	Nursing School/(n=166) first-year and third-year nursing students/Sampling not mentioned/Watson's Transpersonal Caring Theory instrument	Third-year students scored higher in perceptions of caring behaviour as compared to the first-year students. Among the nursing students the most important caring behaviours under the subscales of, "Respectful": 'being respectful to patients', "Teaching / learning":	Study conducted in one university , result may not be generalised.

				‘teaching them’ and “Trusting Relationship”: ‘relationships with patients’	
(Labrague et al., 2017)/ Philippines Greece, Nigeria, India	Explored about the caring behaviours from student nurses in the four countries	Descriptive comparative survey design	Nursing School(n=467) Nursing Students/ Convenient sample/Jean Watson’s theory of human caring based on Watson’s theory of 10 carative factors	Highest rated by the students In the subscale of “assurance of human presence” ‘gives patient treatments and meds on time’ (4.961 ± 1.054). Nurses from the coronary care unit were less competent in skills such as giving injections, administering intravenous medication, and managing and handling equipment (4.630 ± 1.348) and ‘allows the patient to express feelings about his or her disease and treatment’, in the subscale of “Trusting and relationship” ‘treats patient information confidential’ The students rated lowest scores to the	Use of the convenience sample may limit the generalisability of the findings.

				‘empathetic with the patient’ ‘spends time with the patient’ ‘and in knowledge and skills subscale: ‘knows how to give shots, IVs’	
(Aktas and Karabulut, 2017)/Turkey	Correlation of the undergraduate student nurses 'professional values and their caring behaviour.	Cross-sectional descriptive survey design	Nursing School/(n=351) First-Fourth year Undergraduate students/Sampling not mentioned/Nursing Professional Value Scale and Caring Assessment Questionnaire Care-Q	The professional value and care behaviour were found to be lower in the students in the year II than those in the I, III, and IV year.	Study was done on one nursing institution which limits the generalisability of the findings of the study.
(Trinidad et al., 2019)/Universidad Europea de Madrid	Undergraduate student nurses perception about caring and identified any differences in the behaviour among them.	Cross-sectional design	Nursing School/(n=321) Undergraduate nursing students/Sampling not mentioned/Caring Dimensions Inventory (CDI-25)	The most important caring behaviours perceived by the students in the subscale of “Respect”: ‘Providing privacy for a patient’ (M=4.86, SD=0.405) and in the subscale of “Attentiveness”: ‘Listening to a patient’, and the least ranked in “Trusting relationship”: ‘sharing your personal problems with a patient’. First year students consider technical / Instrumental care, however, for third and	Study was done on one nursing institution which limits the generalisability of the findings of the study.

				fourth, psychosocial care is most important.	
(Li et al., 2016)/Taiwan	Comparison of the views about caring behaviors among students and registered nurses	Cross-sectional study	Nursing School and Clinical Setting/ (n=647) Participants from the three programmes (330) nursing students: Five-year ADN programme, the two-year and four-year baccalaureate degree of nursing programmes. (317) registered nurses. from medical, surgical, obstetric, paediatric and intensive care units/ Convenience/Traditional Chinese caring behaviours scale (CBS)	The most important caring behaviour is ‘knowing the patient’, Least important ‘advocating for the patient’, respect the patient's and ‘family's best interests, voicing for them’.	This study took place in a single university, therefore, findings may not be generalised. Proportion of the male was less in order to compare the gender differences.
(He et al., 2013)/ China (Central, Southern, and Eastern)	Comparison of the perspectives among nurses and patients about caring behaviour	Descriptive comparative survey	Five hospitals in southern, central and eastern China. Each three medical surgical unit / (n=1220) Patients and nurses/Convenient sampling/Caring Behaviours Inventory-24.	Both the groups perceived knowledge and skills at the highest level. nurse administered the medication on time (M=4.65). patients and nurses indicated that encouraging patients to call them in case of problems (4.70 and 5.45, respectively).	Convenience sampling was done which limits the generalisability of the study findings.
(Aupia et al., 2018)/Indonesia	Comparison of the perceptions of caring behaviours among	Descriptive comparative study	One Hospital and one nursing school/(n=159) (53) nurses, (53) patients and (53) student /Sampling not mentioned/Caring Behaviour	Students with clinical experiences (8-week) scored higher in the caring aspect connectedness	The study was conducted in one hospital and school of nursing,

	nurses, patients and student nurses. Explored the correlation between demographic variables and the caring. perception		Inventory-42	(t=3.50, p< 0.05) as compared to students with (4-week) of experiences.	therefore, findings may not be generalised.
(Papastavrou et al., 2012)/Six different European countries (Finland , Greece Cyprus, Czech Republic Hungary, Italy)	Perceptions of patients and nurses about caring behaviours.	Descriptive comparative survey	Surgical Unit/ (n = 2854) (1659)Surgical patients and (1195) nurses/Convenient sampling/Caring Behaviours Inventory-24	According to nurses and patients, most important caring behaviour is knowledge and skills. Lowest rated listening to their concerns Patients perceived that nurses did not consider being empathetic as compared to nurses' perceptions. Trusting relationship is rated lowest by patients	Use of convenience sampling which unable to generalise the findings.
(Flynn, 2016)/UK	Perceptions of caring from both patients and healthcare professionals	Descriptive study	Acute hospital trauma ward of the orthopaedic department/(n= 83) (30) Patients and (53) Healthcare Professionals (doctors, nurses, physiotherapists and occupational therapists/Probability Stratified sampling/Caring Behaviours Inventory (CBI) Theory of transpersonal caring	Nurses and patients rated higher score in: “Attentive” subscale ‘attentively listening to the patient’ and ‘watching over the patient’. “Knowledge and skills”, ‘demonstrating professional knowledge and skill’	Participants from the one district general hospital and the low response rate may confine generalisability.

				and ‘giving good physical care’. “Connectedness” patients rated lowest ‘touching the patient to communicate caring’	
(Omari et al., 2013)/Jordan	Perception of patients and nurses about caring behaviours. Comparison of perceptions among both the groups	Descriptive comparative design	Coronary care unit (n=210) (150) Patients and (60) nurses/ Convenience/ Caring Behaviour Assessment	Patients perceived caring behaviours (technical and physical care) as most important, however, nurses perceived teaching/ learning behaviours as most important. Nurses from the coronary care setting clarified the queries raised by the patients (M=4.68), enquired about their understanding (M=4.32), helped them to plan a realistic goal for their health (M=4.30) On instrumental caring behaviours such as knowing how to give injection, IV infusion, and how to handle procedural equipment were not considered the most important by nurses. Nurses commented in	Representation of the sample and response rate was not mentioned.

				this study that competency in skills is not considered as caring behaviour; however, it is a prerequisite for nursing. Furthermore, other nurses believed that explaining procedures to the patients is more important to demonstrate caring behaviour than competent skills. Due to critical nature of the coronary disease, nurses in coronary care units believed that listening to the patients is the most important caring behaviour because patients were more at the risk of psychological distress, such as depression, anxiety, and mood swings, which may lead to further deterioration of heart function. For Muslims, religion directs their actions and thoughts toward God. Patients' religious beliefs and	

				practices are considered as spiritual needs. During their illness, Muslim patients often perform their spiritual religious practices, such as reading the Qur'an (Islam's holy book) and praying. Students and patients from coronary care unit rated the nurses lowest in the trusting relationships. Nurses from the coronary care setting clarified the queries raised by the patients, enquired about their understanding, helped them to plan a realistic goal for their health. The nurses many a times may feel uneasy and inconvenient while providing care to their patients due to the undue visit of their family members.	
(Kiliç and Öztunç, 2015)/Turkey	Comparison of the perceptions of patients and nurses	Descriptive study	Surgical operation department (n=449) (379) Patients and (70) nurses/Sampling not mentioned/CBI-24 (Caring	Patients rated lower score than the nurses in the subscale of: “knowledge and skill” and “being respectful”	Homogeneous ethnic and racial 100% Caucasian sample may not be

			Behaviours Inventory-24)	p<0.001	representative to the target population.
(Edvardsson et al., 2017)/Australia	Association of patients' perspectives about the caring behaviour and person-centeredness with the outcome of quality care nursing.	Descriptive non-experimental correlational design	Tertiary acute-care setting/Patients 210/consecutive sampling/Caring Behaviours Inventory, the Person-centred Climate Questionnaire, the SF-36 and the Distress thermometer	Patients reported that the quality of nursing care is due to effective communication, knowledgeable staff, timely assistance and environmental support, for example, neat and clean ward, feel like home	Use of consecutive sampling and single study site which affect generalisability. Exclusion of the patient with the severe illness or participants were unable to understand or speak English, consequently, the results may be valid for an English-speaking population
(Merrill et al., 2012)/Ghana	Patients perceptions of caring behaviours	Descriptive study	Medical- surgical ward (Trauma centre)/(n=105) Patients/Convenience/Caring Behaviours Inventory/1-to-1 interview	Patients rated the nurses highest in the subscales of “knowledge and skills” "Meeting the patient's stated and unstated needs," "Being confident with the patient," and “Assurance”:"Giving the patent’s treatments and medications on time." Nurses also involved	Questions were not pretested prior to the data collection. However, validity and reliability was mentioned from the previous literature. Study didn't mention about the response bias.

				patients in planning their care such as what they needed to get done on a particular day and develop a planner Rated lowest scores in the subscales of “connectedness” "Touching the patient to communicate caring"	
(Afaya et al., 2017)/Ghana	Patients perceptions about caring behaviour	Descriptive cross-sectional study	Medical- Surgical Ward(n=183) Patients/Probability Systematic sampling Caring Behaviours Inventory-24.	89.1 % patients strongly agreed that nurses attentively listen to them. 87.4% respondent perceived they gave instructions and taught them. 91.8% of respondents perceived that nurses were competent in giving injection and administering IV medications. 90.2% indicated that nurses were having professional knowledge and skill. In accordance with 91.2% of participants, nurses appeared concerned when attending to them. The top ranked caring	The study didn’t discuss about the representation of the sample

				behaviours, according to 92.9% of respondents, involved nurses giving patients their treatment and medication on time.	
(Youssef et al., 2013) /Taif City	Perceptions of caring behaviours from nurses	Quantitative descriptive correlational design	Medical-Surgical Nurse's/(n=90) /Convenience sample/Watson's Tanspersonal theory (CBA)	Nurses treat the patients as an individual and respect them. 'Be kind and considerate' to be the most important caring behaviours (4.3±0.9) and help them how to achieve goals (4.3±5.2) In Trusting relationship, nurses perceived the least important caring behaviours 'Touch me when I need it for comfort' (2.8±1.4)	Use of nonprobability convenience sampling, can't generalise the findings.
(Roulin et al., 2020)/Geneva, Switzerland	Describes and compares nurses' and admitted patients' perceptions of caring behaviours	Comparative descriptive design	Rehabilitation Nurses (n=34) Elderly (n=64) Convenience Watson Caring Nurse Patient Inventory-23	Patients perceived nurses knew what to do in emergency situations and act quickly Least important caring behaviour of nurses (Patients) Nurse considered patients as an individual and not	Sample size was not calculated Convenience sampling instead random affects validity

				only interested in resolving health problems Least important caring behaviour (Nurses) Provided opportunity to the patients to take care of themselves Give treatment and medication on time.	
(Thomas et al., 2019)/North Texas	Congruency of perceptions of nurse caring behaviour between patient and nurse. Determine patient perception changes over time.	Mixed Methods Triangulation Design	Long-term acute care hospital Convenience Patients (n=25) Caring Assessment Tool (CAT-V) filled during first 1 to 2 weeks after admission and during the week of discharge Nurse= (n=85) brief stories (patient and family encounter)	Patients and nurses considered nurses showing respect towards patients The patients report higher satisfaction when nurses provide physical comfort by fulfilling their basic physical needs Patients rated low scores to nurses for asking about patients' knowledge of their illnesses. Nurses described they informed them 'about their illnesses, not asking about their knowledge of their illnesses.' Patients rated high scores to nurses for 'helping them feel	Non probability sampling techniques (Convenient) was used which does not represent the target population.

				comfortable or attending to their basic physical needs’ They discussed with the patients about care planning of the day. The least caring behaviours were talked to the patients while providing care to them.	

Appendix F Topic interview guide

Demographic Data

Patient data

Age (In Years) _____

Gender: ☐ Male ☐ Female

Hospital: ☐ Public ☐ Private

Department: _____

Qualification: _____

Number of hospitalisations_____

Topic interview guide

Topics	Interview questions	Probing questions
Caring	What do you understand by caring?	What is meant by caring? What is your point of view about caring? What kind of caring behaviour do you receive from nurses? How do nurses behave towards you? Can you give me an example? What kind of caring behavior did you like most during hospitalization? What kind of caring behaviour is least important for you during hospitalization?
Expectation of the patients	What kind of caring behaviour do you expect from nurses?	What advice do you give to the nurses regarding caring behaviour?
Autonomy	What do you understand by the term patient's autonomy (Independence)?	How do nurses involve you in your own care? How do nurses support your decision?
Spiritual care	What are your spiritual (Religious) needs?	What are your daily practices to satisfy your spiritual (Religious) needs?

	How do nurses fulfill your spiritual (Religion) needs during hospitalisation?	What kind of spiritual care is provided by nurses?
Cultural care	What are your cultural (ethnic or traditional) needs?	Tell me about your rituals and tradition important for you?
	How nurses fulfill your cultural (ethnic or traditional) needs?	What type of cultural care is considered by nurses?
Counseling	How nurses advise or guide you on your health issues?	How do nurses explain to you about your health issues? How is it discussed by them?

Demographic Data

Nurse data

Age (In Years) _____.

Gender: ☐ Male ☐ Female

Hospital: ☐ Public ☐ Private

Department: _____ Specialty_____

Professional Qualification: ☐ BSN ☐ Post RN-BSN ☐ Diploma

Job Experience: _____.

Topic interview guide

Topics	Interview questions	Probing questions
Caring	What do you understand by caring?	What is meant by caring? What is your point of view about caring? How do you demonstrate caring behaviours towards patients? Can you give me an example? What kind of caring behaviours a nurse should demonstrate?

		What kind of behaviours do you considered the most? What are the characteristics of a caring nurse? Why is caring important?
Educational training	What kind of training related to caring behaviour did you receive in your nursing programme?	What did you learn from this training? How does the training influence your caring behavior? Have you had further training related to these ethical values? How do nurse educators emphasise caring behavior in the students? What teaching strategies can they use to teach caring behaviour?”
Spiritual care	How do you assess the spiritual (Religious) needs of the patients?	What do you enquire regarding spiritual (Religious) needs of a patient?
	How do you provide spiritual (Religious) care to the patients.	What rituals or practices do you allow to the patient?
		How do you develop hope in patients?
Autonomy	What do you understand by the term patient’s autonomy?	How do you involve patients in planning their care? How do you support patients to become independent in their own care? How do you assist your patient in making appropriate treatment decisions?
Cultural care	What does it mean by culturally sensitive care?	What do you understand by culture-related care?
	How do you fulfill the cultural needs of the patient?	What kind of cultural-related care do you provide to the patients? How do you sure about cultural needs are met? What type of cultural care do you think should be considered by nurses?

Counseling	How do you counsel the patients?	How do you explain to your patients about their health issues? How do you discuss with them? How do you advise or guide them about their health issues?
Advocacy	What do you know about patient's advocacy?	How do you support the patients to speak for their rights? How do you coordinate and communicate between healthcare team members to speak for the patients? Can you share any experiences?

Demographic Data

Student nurse data

Age (In Years) _____.

Gender: ☐ Male ☐ Female

Nursing Institution: ☐ Public ☐ Private

Programme of studies: ☐ BSN ☐ Post RN-BSN

Year of studies: _____

Topic interview guide

Topics	**Interview questions**	**Probing questions**
Caring	What do you understand by caring?	What is meant by caring? What is your point of view about caring? How do you demonstrate caring behaviours towards patients? Can you give me an example?

		What kind of caring behaviour does a nurse demonstrate towards patients? What kind of caring behaviours a nurse should demonstrate? What kind of behaviours do you considered the most? What are the characteristics of a caring nurse? Why is caring important?
Educational training	What kind of training related to caring behavior did you receive in your nursing programme?	What did you learn from this training? How does the training influence your caring behavior? How do nurse educators emphasise caring behavior in the students? What teaching strategies can they use to teach caring behaviour?
Spiritual care	How do nurses assess the spiritual (Religious) needs of the patients?	What do they enquire regarding spiritual (Religious) needs of a patient?
	How do they provide spiritual (Religious) care to the patients?	What rituals or practices do they allow to the patients?
		How do you develop hope in the patients?”
Autonomy	What do you understand by the term patient’s autonomy?	How do nurses involve patients in planning their care? How do they support patients to become independent in their own care? How do they assist your patient in making appropriate treatment decisions?
Culture care	What does it mean by culturally sensitive care?	What do you understand by culture-related care?

	How do nurses fulfill the cultural needs of the patient?	What kind of cultural-related care do they provide to the patients? How do they make sure about cultural needs are met? What type of cultural care do you think should be considered by nurses?
Counseling	How do nurses counsel the patients?	How do they explain to the patients about their health issues? How do they discuss with them? How do they advise or guide them about their health issues?
Advocacy	What do you know about patient's advocacy?	How do nurses support the patients to speak for their right? How do they coordinate and communicate between healthcare team members to speak for the patients? Can you share any experience?

Appendix G Participant information sheet for patients

UNIVERSITY OF LEEDS

School of Healthcare (Faculty of Medicine and Health)

The title of the research project

Perceptions of caring behaviours among patients, nurses and student nurses in Islamabad, Pakistan

Introduction

I am Nafisa Iqbal and I am doing a PhD from the University of Leeds supervised by Dr Janet Holt & Professor Gretl McHugh. I am inviting you to take part in my research and this would involve taking part in an interview with to learn about your understanding of what 'caring' is. Before you decide to participate in my study, it is important for you to have further information about my research project. Please read this information sheet so that you can make an informed decision about your participation. You may wish to discuss this information with others to help you make your decision. You are welcome to contact me for further clarification.

Purpose of the project

The foundation and core value of the nursing profession is caring. When good care has been provided to the patients, it ultimately results in having a positive effect and a sense of satisfaction on the life of the patients.

The aim of this study was to explore the perceptions of patients, nurses, and student nurses regarding nurses' caring behaviours in Pakistan and develop an educational programme to enhance knowledge and understanding of the importance of caring in practice.

I would like to find out what people think about caring behaviour or what caring behaviour means to them.

My PhD project will be completed on September 30th, 2022, and the interview, I hope you will take part in will be conducted in the next few weeks.

Why have I been chosen?

You have been chosen because you are currently a patient who will have experienced nursing care. I will also be asking other patients and invite them to take part in an interview. I need around (10) patients to take part.

Do I have to take part?

It is a voluntary decision for taking part in the study. If you decide to take part in the study, you will be asked to complete and sign a consent form indicating your agreement to participate. You may wish to withdraw from the study without giving any

reason during and up to one week after data collection. It will not be possible to remove your interview data once the analysis has begun.

What do I have to do? / What will happen to me if I take part?

I will ask you to talk to me about your experience of the care you have received from the nurses. This would take no longer than 60 minutes. With your permission, I will record our interview using a digital voice recorder. This interview will be listened and then it will be transcribed by me so that the data can be analysed. I will be the only one who knows who you are, and the transcript will be anonymised, so no real names will be used. Only myself and my supervisors will have access to the transcripts, and these will be kept on a password-protected computer at the University and deleted at the end of my research project.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks of taking part in the study. However, you will be giving some of your time for the interview.

What are the possible benefits of taking part?

There are no immediate benefits for you participating in the study. However, the data obtained through the interview will help me to understand more about caring and from the findings, I am going to develop ways of educating nurses about caring. In the long term, the learning from this project may help change nurses' behaviour and ultimately help in improving patient care.

What will happen to my personal information?

All the information shared by you will be kept confidential. It will be only accessed by my PhD supervisors who will have access to audio recordings and transcripts. All the study documents will be kept locked in a locked filing cabinet. All the interview transcripts will be anonymised and will be saved in the password- protected computer. Anonymise means your identity will be removed from the data and numeric I.D codes will be used. All the hard copies of the study documents can be scanned, saved in the computer, and will then be shredded. The data for my PhD study will be kept for the five years and after this time will be discarded.

What will happen to the results of the research project?

The interview data from all the patients who are interviewed will be collated together and analysed. I may also with your permission use direct quotes from what you say to me during the interview. But your name will not be used, and you will not be identifiable from the quotes. Your identity and any other information about you will be stored separately from the actual research data. After I have analysed the data, it will be written up in my PhD thesis; some of the findings may be published in a journal and presented at conferences and seminars.

Who is organising/ funding the research?

I am from Shifa Tameer-e-Millat University, Islamabad and a post graduate research student at the University of Leeds, United Kingdom.

Contact for further information

Name: Nafisa Iqbal

Address: Pitras Bukhari Road, Sector H-8/4, Islamabad, Pakistan.

Telephone number: 03335342726

Supervisor –name: Dr. Janet Holt

Email hcsjh@leeds.ac.uk

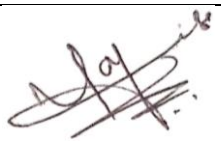
Thank you for taking the time to read through the information and participation in my research project!

Appendix H Participant consent form for patients, nurses, and student nurses

Title of the project: Perceptions of caring behaviours among patients, nurses and student nurses in Islamabad, Pakistan.

	Please read the statements carefully and if you agree, put your initials next to the below mentioned statements.
I confirm that I have read and understand the information sheet dated [insert date] explaining the above research project and I have had the opportunity to ask questions about the project	
I understand that my participation is voluntary and that I am free to withdraw from the study during and up to one week after data collection without giving any reason and without there being any negative consequences. It will not be possible to remove your interview data once the analysis has begun.	
I understand that my interview will be audio recorded.	
I understand that members of the research team may have access to my anonymised data. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential	

I understand that the data I provide may be archived at University computer for five years.	
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of Participant	
Participant's signature	
Date	
Name of Lead researcher	Nafisa Iqbal
Signature	
Date	

Appendix I Questions to be asked from the stakeholders

Questions	Probing
Does the learning objectives and content of the course understandable?	Are the objectives relevant to the course content? Which objectives need to be written correctly? Does the content give you concrete idea of caring behaviour? Have you identified the content in a logical manner? Are the numbers of objectives sufficient to achieve the programme outcomes?
Does the course provide new information?	Could you give me an example, how this course could be beneficial for nurses? Provide an example of how this new information will impact nursing profession?
Are the teaching strategies relevant with the course objectives?	How teaching strategies help to achieve learning outcomes? Could you give me an example of any other teaching strategy relevant to the content?
Does the length of the course appropriate to cover the content?	What do you think that the duration of the course was enough to meet the learning outcomes? Do the teaching contact hours per day is enough to meet programme outcomes?
Do the evaluation methods appropriate?	Do you think evaluation method is appropriate to evaluate the learning outcomes? How did you find the appropriateness of overall programme evaluation? Do you suggest any other evaluation methods?

Can you describe positive and negative aspects of the course?	Is there any deficiency in the course? How to improve that deficiency?
Do you have any suggestion to improve the course?	Any recommendations/feedback on objectives, content, teaching strategies, and evaluation criteria? Any other recommendations?

Appendix J Instructional design based on Gagne's model

Gaining attention	**Informing the learner of the objectives**	**Stimulating recall of prerequisite learning**	**Total learning time (face-to-face teaching and self-directed learning)**	**Presenting the stimulus material & providing learning guidance**	**Eliciting the performance (practice)**	**Assessing performance & providing feedback**	**Enhancing retention and transfer**	**Resources**
Initiate the session with the images of caring behaviours	**Session 1** Learners will perform pre-test to evaluate their caring behaviours Lecture on introduction to caring concepts and related behaviours (see Table 15) Learners will identify	Through questioning (What is your understanding about the caring concepts?) Learners should be encouraged to share their past and current experiences	Interactive lecture (120 min)	Live classroom session Through an interactive lecture Encourage questioning Provide written hand-outs to the learners.	N/A	Pre-class Caring behaviour questionnaire will be filled by the learners	Provide PPT and other resources for the retention of knowledge Encourage learners to apply this learning into clinical practice	Hand-outs PPT Writing pad with pen Multimedia Questionnaire Speakers White board

	different caring concepts and related caring behaviours.							
	Session 2 Introduction to reflective writing Learners will identify the reflection process. Learners will reflect their caring experiences.	Learners will share the past experiences of writing reflections.	Interactive lecture (60 min) **Self-directed learning** Writing reflection (60 min)	Interactive lecture	N/A	The learners will submit their reflections every week First assignment: reflection on positive and negative experiences by themselves or by observing their colleagues	The learners will gain clinical experiences	Continue with the above resources
	Session 3 Learners will summarise the learning points.	N/A	Summarisation of learning (30 min) Total time= 270 min/04 hrs (03 hrs face-to-face teaching and 01 hr self-directed learning	Explanation and summarisation of the learned knowledge by learners	N/A	Feedback on summarisation of the content	Learners gain clinical experiences	N/A

	After one week							
NA	**Session 1** Learners will discuss the findings of the reflection.	N/A	Group discussion on reflection (60 min)	Interactive discussion	Learners share their experience regarding caring behaviours	Feedback on reflection by peer and faculty	Learners apply learned knowledge into clinical practice	Writing pad with pen Multimedia Speakers White board
NA	**Session 2** Discussion on learned concept by using different teaching strategies Learners will analyse interpret and explain the caring behaviours of nurses.	Learners will share the past experiences of caring behaviour.	Review images 03 min (each for three images) Total time=9 min Review case scenario 10 min (each for four case scenarios) Total time= 30 min Watch video 6 min (each for five videos) Total time=30 min For the discussion on these learning tools (60 min) **Self-directed learning** Writing reflection (60	Interactive discussion	Hands-on activities such as: Small group discussion on various learning tools Critical thinking and decision making through reflection	Provide feedback on performance Learners will submit second reflection after one week	Learners apply learned knowledge into clinical practice	Writing pad with pen Multimedia Speakers White board Videos Case scenarios Images

			min)					
NA	**Session 3** Learners will summarise the learning points.	N/A	Summarisation of learning (45 min) Total time= 294/5 hrs (4 hrs face-to-face teaching and 01 hr self-directed learning)	The session can be closed by reviewing the key points, answering questions and asking for learners' feedback.	N/A	Feedback on summarisation of the content	Learners apply learned knowledge into clinical practice	N/A
NA	After one week **Session 1** Learners will discuss the findings of the reflection.	N/A	Group discussion on reflection (60 min)	Interactive discussion	Learners share their experience regarding caring behaviours	Feedback on reflection	Learners apply learned knowledge into clinical practice	Writing pad with pen Multimedia Speakers White board
NA	**Session 2** Introduction to journal club as a teaching and learning strategy. Learners will be able to: Recognise	Learners will share the past experiences of caring behaviour	Lecture (30 min)	Lecture	N/A	N/A	N/A	Writing pad with pen Multimedia Speakers White board PPT Articles

	journal club as a teaching strategy.							
NA	**Session 3** Discussion on articles related to caring behaviours of nurses. Identify caring behaviours that the nurses have in their clinical practice. Identify expectations of the patients regarding caring behaviours of nurses. Learner will	N/A	**Self-directed learning** Writing reflection (60 min) Review the articles (60 min each for three articles) Total time= 180 min Group discussion on reviewed articles (60 min)	N/A	Group discussion on the articles	Feedback on review of the articles. Learners will submit the third reflection on implementation of learning through articles.	Learners apply learned knowledge into clinical practice	Articles

	implement caring behaviour in the clinical practice.							
NA	**Session 4** Learners will summarise the learning points.	N/A	Summarisation of learning (30 min) Total time=420/07hrs (03 hrs face-to-face teaching and 04 hrs self-directed learning)	Explanation and summarisation of the learned knowledge by participants	N/A	Feedback on summarisation of the content	Learners apply learned knowledge into clinical practice	N/A
NA	After one week **Session 1** Learners will discuss the findings of the reflection.	N/A	Group discussion on reflection (60 min)	Interactive discussion	Learners share their experience regarding caring behaviours	Feedback on reflection	Learners apply learned knowledge into clinical practice	N/A
NA	**Session 2** Use of role play strategy Learners will identify caring behaviours	N/A	Role play for 15 min (each for four role plays) Total time=60 min Learners will reflect on the role plays	Demonstration of caring behaviours through role play	Analysis and interpretation of the role play	Feedback on discussion on role play	Learners apply learned knowledge into clinical practice	Actors for role play Equipment for assuming the role of patient, nurse, doctor and family member

			(60min)					
NA	**Session 3** Learners will summarise the learning points.	N/A	Summarisation of learning (30 min) Total time=210/04 hrs	Explanation and summarisation of the learned knowledge by the learners	N/A	Feedback on summarisation of the content.	The participants apply learned knowledge into clinical practice	N/A
NA	**Session 4** Learners will perform post-test to evaluate their caring behaviour. Learners will evaluate the effectiveness of the programme.	N/A	Fill the questionnaire (60min) Fill the questionnaire (30 min) Total time=90 min	Caring behaviour questionnaire Programme evaluation questionnaire	N/A	Learners will assess their caring behaviour Learners feedback on programme	Same as above	Questionnaires