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Transformation of Clinical Nursing Practice Following a Caring-based Educational Intervention: A Qualitative Perspective

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Abstract

Introduction: Hemodialysis (HD) patients experience numerous physical and psychological symptoms on a daily basis. These symptoms have a heavy impact on their quality of life, which is a key indicator of their survival in the short term. Numerous empirical studies have shown that the quality of the nurse-patient relationship (NPR) is essential in promoting positive outcomes for patients. When patients receive caring, their autonomy and independence grows, their sense of hope increases, their quality of life improves, and their sense of satisfaction with nursing care received rises. Inversely, the presence of dehumanizing practices in hemodialysis settings can contribute to delay healing for patients. In light of the importance of the quality of the relationship between nurses and HD patients and of the benefits to be had from a quality relationship, an educational intervention based on Watson's Theory of Human Caring was delivered to HD nurses.

Objective: The purpose of this study was to explore qualitatively the perceptions of nurses working with HD patients in French-speaking Switzerland regarding changes to their clinical practice after receiving an educational intervention intended to reinforce caring attitudes and behaviors towards patients.

Methods: The method used was that of consensual qualitative research (CQR). Sixteen semi-structured interviews were conducted with hemodialysis nurses post-intervention.

Results: The results evidence a transformation of clinical nursing practice illustrated by three core ideas: (1) caring practice was reinforced; (2) new practices emerged; and (3) some limitations appeared.

Conclusion: In these times of global pandemic where the issue of the humanization of nursing care is front and center, this professional development activity helped reinforce caring-based practice. This practice needs to be developed within the various care units in order to guarantee and promote quality of care and patient safety.

Keywords

consensual qualitative research, educational intervention, transformation of clinical nursing practice, nurse-patient relationship, Watson's Theory of Human Caring

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Introduction

Caring is defined as helping people give meaning to their existence and suffering through a humanist relationship (Watson, 2008, 2012). Its aim is to transform patient care from treatment geared to symptom reduction to a holistic recovery-focused approach that strives for harmony between body, mind and spirit (Sitzman & Watson, 2014; Watson, 2012). According to Watson's Theory of Human

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Caring, the quality of the nurse-patient relationship (NPR) constitutes a core dimension of nursing care (Watson, 1985, 1988, 1999, 2008, 2012). Empirical studies (Delmas et al., 2016, 2018, 2020; Lee et al., 2008; O'Reilly, 2007; Swanson, 2013) have shown that the quality of the relationship is key to promoting positive outcomes for both patients and nurses.

Regarding patients, nurses play a major role particularly in fostering a sense of safety and wellbeing in those living with a chronic condition and in providing the support that they need to cope with their situation (Caruso et al., 2008; Lovink et al., 2015; Shahgholian & Yousefi, 2015). Among these patients, those who receive hemodialysis (HD) experience numerous physical and psychological symptoms on a daily basis owing to the intensity and frequency of treatment (Weisbord et al., 2008). In this context, Hreńczuk (2021) showed that the therapeutic NPR was important in all renal replacement therapies. The quality of the relationship, which is based on empathy, mutual trust and respect, was critical to strengthening patient sense of security and quality of medical care. Although HD patients mentioned that the relationship with nurses was generally therapeutic, they stressed that its continuous improvement should be considered, especially where care was technology intensive. Where nurses are concerned, self-esteem, sense of personal accomplishment and work satisfaction have been observed to improve when caring attitudes and behaviors are applied in daily clinical practice (Swanson, 2013). Moreover, the presence of dehumanizing practices in their daily work might increase risk for burn-out and depression (Beagan & Ells, 2007; Brown et al., 2006; Diniz et al., 2019; St-Germain et al., 2008).

In this light, it is imperative to provide nurses with the right instruments to create a positive NPR. Though these are covered and developed in most nursing programs, everyday routine and demanding work conditions tend to undermine these skills and abilities. This is why continuing education programs to prevent dehumanizing practices need to be created and tested.

In this paper, we present how nurses perceived changes to their clinical practice after receiving an educational intervention based on Watson's Theory of Human Caring (2012) and intended to reinforce caring attitudes and behaviors towards patients.

Literature Review

Recent studies have shown that increased use of technology in patient treatment and care could keep nurses from knowing and understanding the current actual needs of their patients (Cuchetti & Grace, 2020; Wilson et al., 2019). This encouraged standardization and automatization of the care process, which could lead to dehumanized care (Busch et al., 2019; Lovato et al., 2013). In the context of HD units, Bennett (2011) pointed out that the technological element was central and that the danger lay in nurses responding primarily to the needs of the technology rather than those of the patient, thus creating a tension between "curing" and "caring". Similarly, the results of the phenomenological study by Moran et al. (2009) underlined that the main contacts that patients had with nurses were to manage physical and technical aspects of care.

Unsurprisingly, recent research has underscored the presence of dehumanizing practices in HD units and the need to address the problem (Aasen et al., 2012a, 2012b; Cuchetti & Grace, 2020). When uncaring behaviors are widespread, patients are treated as passive objects of care (Aasen et al., 2012a) and nurses feel that they "are just running the factory" (Aasen et al., 2012b, p. 423).

This is why the quality of the NPR, which is at the core of the caring approach to nursing (Watson, 2008, 2012), must be reinforced regularly in these units.

Against this background, we developed an educational intervention for HD nurses grounded in the Theory of Human Caring and intended to strengthen caring attitudes and behaviors (O'Reilly et al., 2016). The intervention was tested and validated in a pilot study in the French-speaking part of Switzerland (Delmas et al., 2016). The study's positive results led to the development of a large-scale mixed methods study. The purpose of the present article is to lay out the results of this study's qualitative component (Delmas et al., 2018).

The study's quantitative component served to measure the effects of the educational intervention on the caring attitudes and behaviors of HD nurses, as well as on their quality of working life (Delmas et al., 2018). The results demonstrated a clear intervention effect on strengthening of nurse caring attitudes and behaviors over time. They also showed that nurse quality of working life improved (Delmas et al., 2020).

Ours was not the first intervention study based on Watson's Theory of Human Caring. A systematic review of the literature found 19 such studies (Wei et al., 2019). All sought to promote the mental health of patients, nurses and nursing students, and quality of care for patients. Sixteen of the studies described the effects of a given intervention using a purely quantitative approach. Aside from our pilot study, only two studies applied a mixed methods design that allowed exploring change brought about by the educational intervention in terms of clinical practice (Broscious et al., 2015; Wu et al., 2009). The first concerned patients in a rehabilitation care unit and the second involved nursing students. In short, change in clinical nursing practice further to an educational intervention had seldom been investigated from a qualitative perspective. In our study, the qualitative exploration of change in nurses following an educational intervention was meant to provide an in-depth understanding of the mechanisms of change in nurses' practice. The results of our qualitative study were expected also to help refine the pedagogical processes and content of the

existing educational intervention in the aim of reinforcing and improving the quality of care and safety of HD patients.

Objective

The objective of our study was to conduct a qualitative exploration of how nurses working with HD patients in French-speaking Switzerland perceived changes to their clinical practice after they received an educational intervention intended to reinforce caring attitudes and behaviors towards patients. Given the abundance of data collected, this article will focus primarily on the "transformation of clinical nursing practice".

Methods

Design

Consensual Qualitative Research (CQR) was the design used in the qualitative component of the study (Hill, 2012, 2015; Hill et al., 1997, 2005). CQR is a data-driven qualitative method that uses a team consensus approach and entails the systematic evaluation of thematic representativeness across multiple cases. This method is based on data collected through in-depth individual semi-structured interviews that include open questions. The discourse contained in interview transcripts is examined in detail using a structured iterative procedure aimed at reaching consensus among various researchers (Hill, 2012; Hill et al., 2005). Finally, this research method is suited to investigating, in depth and with precision, personal experiences hard to seize through quantitative data (Hill, 2015).

Sample and Recruitment

The study population consisted of nurses working in the HD units of ten hospitals in the French-speaking Switzerland. To be included in the study nurses had to have at least six months' work experience in their HD unit and consent to participate. In addition, nurses who intended to leave their HD unit within three months were excluded.

A convenience sample was used. This sampling method allowed selecting persons who had experience of the phenomenon under study (in our case, participation in an educational intervention) and who agreed to share it. Participants for this component of the study were selected from among the nurses in the HD units who received the educational intervention. Moreover, to take account of staff heterogeneity across these units, the number of participants invited to be interviewed was weighted based on unit size.

According to CQR guidelines (Hill, 2015), 8 to 15 interviews are required. This sample size is ideal for evidencing common tendencies among participants without generating a flood of data (Hill, 2012). However, to consider ideas that fall into "rare" categories in terms of representativeness, a minimum of 16 are required (Hill, 2012). CQR analysis affords the possibility with a minimum of 16 interviews to determine the representativeness of categories and subcategories based on the frequency of core ideas (Hill, 2012). The size of our sample was thus set at 16 participants.

We met beforehand with the head nurses of the HD units to explore the possibility of their units participating in the study. With their consent, we then scheduled meetings with the nurses in each unit to present the study and hand out consent forms. Interested parties could return the forms by mail if they wanted more time to consider the proposal. A nurse coordinator was named in each HD unit to facilitate communication with researchers and data collection.

Educational Intervention

The caring-based educational intervention comprised four 3.5-h sessions in all, one a week for four weeks (Delmas et al., 2018). The groups were composed of five nurses at most in order to facilitate interaction and exchanges within the group. Sessions included a theoretical section, practical exercises, and role play. Focusing exercises (Gendlin, 1998) were proposed at the start of each session to foster greater receptiveness and to mark a break between training time and work time with HD patients. In terms of content, the first session covered the core concepts of Watson's Theory of Human Caring and ended with a discussion of the clinical situation of a HD patient (Watson, 2008, 2012). In the second session, the ten carative factors proposed under the Theory of Human Caring were presented and discussed. A clinical situation was presented to illustrate how these factors apply with HD patients from a clinical viewpoint. The third session served to introduce the concepts of hope and resources. Tools were presented to help participating nurses foster hope and awareness of the resources that HD patients possess. Finally, the nurses practiced using the AERES patient resource self-assessment instrument (Bellier-Teichmann et al., 2018). In the fourth session, a simulation was organized to review the theoretical concepts and to put into practice the theory and the tools covered during the intervention. The simulation included a briefing session to allow participants to prepare a scenario in which to enact an intervention and concluded with a debriefing session to collect feedback from participants and instructors.

The goal of this intervention was to help nurses reframe their activity around the humanistic foundations of nursing and foster optimum appropriation of the concepts presented. While caring is a central part of nursing widely taught in nursing schools, it may fade over time. This intervention was meant to help nurses rediscover and reinforce it.

Data Collection

Semi-structured interviews were conducted from May 2018 to October 2018 with 16 nurses who received the educational

Table 1. General Analysis Grid in Accordance with CQR (Hill et al., 2005): Domains, Categories and Subcategories to Emerge from Study's Qualitative Analysis.

Domains	Categories	Subcategories
Transformation of clinical nursing practice	Caring-based practice was strengthened	Patient-centered practice was strengthened
		Importance of relational care was highlighted
		Active listening attitudes were strengthened
		Patient wellbeing became overarching priority
		Quality of relationship with patients improved
	New practices emerged	New interventions planned or initiated
		New perspective and common language emerged
		Self-reflection and reflection on personal practice emerged
	Limitations appeared	No perceived change in practice following EI
Transformation of teamwork in unit	Quantity and quality of interactions between nurses were strengthened	Nurses interacted more regarding lived experience of patients
		Support and solidarity between nurses was strengthened
		Atmosphere at work became more harmonious
	Limitations appeared	No perceived change in teamwork
EI effects on nurses	Quality of work life strengthened	Nurse wellbeing at work improved
		Negative emotions at work diminished
		Situations with patients considered difficult were handled more serenely
	Perception of self and profession changed	Nurses perceived more value and legitimacy of their profession
		Level of self-awareness was strengthened
Nurse-perceived EI effects on patients	Patient quality of life strengthened	Patients shared their lived experience more with nurses
		Patients perceived improvement in patient management by nurses
		A positive emotional state was promoted in patients
Intervention characteristics	Pedagogical processes and content fostered enrichment of practice	Intervention's pedagogical supports and content yielded benefits
		Exchanges between instructors and participating nurses were beneficial
		Intervention's content was appreciated
		Training would merit wider dissemination
	Benefits of resource assessment tool demonstrated	Resource assessment tool perceived as beneficial
		Resource assessment tool facilitated relational closeness with patients
	Limitations appeared	Ways to improve training were identified
Contextual barriers	Work context constitutes barrier to implementation of caring-based practice	Presence of crisis in structure was identified
		Management ill-inclined to caring source of resistance against training
		How work was organized constituted brake to practicing caring
Other	Several pre-intervention team characteristics named	Difficulties and dehumanizing practices were identified in team
		Team presented some positive dimensions
		Presence of Neutral elements and some questioning present post-intervention

intervention. The interviews were led by a researcher with expertize in qualitative interviewing. These were held one month post-intervention. As interventions were provided site by site, sometimes several weeks apart, the interviews were similarly staggered over time. Each interview was one on one, lasted 60 min, and took place at the nurse's workplace in a space propitious to developing a relationship of trust. Interviews were recorded and then transcribed in their

entirety. They were then anonymized and coded according to the CQR analysis method (Hill, 2012) by the researcher coordinating the study's qualitative component. This researcher also ensured quality control by re-listening to certain passages against the transcripts. The nurses' sociodemographic data were collected during the study's quantitative section.

The data used in this qualitative study were collected using the semi-structured interview guide summarized below. The guide was developed by a group of researchers specializing in qualitative analyzes.

Insert interview guide for exploring nurse perceptions

Data Analysis

The CQR method (Hill, 2012, 2015; Hill et al., 1997, 2005) comprises seven major inter-related steps: *1. Develop research questions*. *2. Conduct and transcribe semi-structured interviews*. *3. Develop domains.* The analysis was performed by a triad of researchers expert in qualitative analysis. Once the domains were defined, an external auditor reviewed the results. This was done by Professor Roulet-Schwab, an expert in qualitative analysis. As she had not participated in data collection or analysis, her feedback was completely independent of the work of the rest of the research team. In accordance with the CQR method, five interviews were selected consensually in keeping with the criteria of content heterogeneity and clarity (Hill, 2015). These were analyzed by the triad in the aim of agreeing upon a common coding scheme in order to arrive at a consensual list of domains. The domains were then tested against the other transcripts for exhaustiveness and fit. That work allowed identifying four main domains or general semantic categories. *4. Construct core ideas for each participant within each domain*. Each interview was then broken down into segments in order to construct its core ideas. In accordance with the CQR method (Hill, 2012), each segment was rewritten as a concise summary statement using the very words used in the interviews as much as possible. These statements corresponded to core ideas that reflected the essence of what each participant expressed within each domain for each unit of meaning to emerge (Hill, 2012). *5. Establish consensus between researchers on domains and core ideas for each participant.* Each transcript summarized into core ideas was then finalized consensually by the triad. These core ideas were then assigned consensually to a domain. Once the domains and core ideas were established, the external auditor reviewed the results to ensure that the raw data were properly categorized and that the core ideas reflected the data in a relevant manner (Hill et al., 2005). *6. Cross-analyze*: *develop categories and subcategories within domains for each participant.* Cross-analysis consists of identifying common themes across participants. The categories and subcategories obtained are summarized in Table 1, which presents a general analysis grid according to the CQR (Hill et al., 2005). *7. Reach consensus on cross-analysis*. The categories and subcategories were reviewed by the triad in order to arrive at a consensual definitive list. The external auditor then reviewed the list. CQR qualitative analysis also affords the possibility of determining the representativeness of the categories and subcategories according to frequency of occurrence of core ideas. Hill (2012) proposed four levels of representativeness: general, typical, variant or rare. Categories and subcategories are considered general when they are mentioned by all participants or all but one, which in our case meant at least 15. They are typical when they concern more than half of the participants (i.e., at least nine in our case), variant when they concern from three participants to up to half the sample, and rare when they concern only one or two participants.

Ethical Considerations

In compliance with the Federal Act on Research involving Human Beings, our study was submitted for approval to the Ethics Committee Vaud (CER-VD). All nurses had two weeks to decide whether to take part in the study before signing the consent form. They were free to withdraw from the study at any time. As participation in the intervention could elicit different emotions, help from a certified psychologist was offered to participants free of charge. The qualitative interview counted as 1 h of work for each participating nurse.

Scientific Rigor Criteria

Whittemore et al. (2001) proposed four primary and six secondary criteria in this regard. The primary scientific rigor criteria include credibility, authenticity, criticality and transferability. These were applied in this study. The CPR method involves strict procedures to preserve the experience of interviewed people (credibility) and describe the differences in the words of all participants (authenticity). Reformulating the utterances of interviewees is possible but limited and is subject to the consensus of all the researchers involved in the analysis. Moreover, the auditor must check whether the analysis respects the criteria of credibility and authenticity. The presence of a research team and of an external auditor, all of whom must agree on the interpretation of the data, provides an efficient way to ensure that results are grounded in the data collected (integrity) and that bias related to each researcher's values and vision is reduced as much as possible (validity).

Results

Sample Sociodemographic Characteristics

Qualitative interviews were conducted with 16 nurses from the ten HD units in French-speaking Switzerland: Jura (Delémont and Porrentruy, 5 nurses) Martigny (2 nurses), Morges (1 nurse), Payerne (3 nurses), Monthey (2 nurses),

and Yverdon (3 nurses). Our sample was composed of 14 women and 2 men, which reflected the gender split in these units. At time of study, the nurses had a mean age of 44 years (SD = 8.8) and had 11 years (SD = 6.8) of HD work experience on average. Nurse sociodemographic characteristics are presented in Table 2.

Findings

Data analysis yielded seven principal domains, the first four of which emerged from analyzing the five interviews selected consensually (Hill, 2015). Three other domains emerged over the course of analyzing the other 11 interviews: (1) *transformation of clinical nursing practice*; (2) *transformation of teamwork in unit*; (3) *educational intervention effects on nurses*; (4) *nurse-perceived educational intervention effects on patients*; (5) *intervention characteristics*; and (*6) contextual barriers*. The seventh domain, *other*, was added in accordance with CQR guidelines (Hill, 2012). Table 1 presents a general analysis grid (Hill et al., 2005).

Given the wealth of data that was collected, this article will focus primarily on domain 1, *transformation of clinical nursing practice*, and its corresponding categories, subcategories and core ideas

Transformation of Clinical Nursing Practice

Regarding transformation of clinical nursing practice, the following three categories were identified: 1. caring practice was strengthened; 2. new practices emerged; and 3. limitations appeared.

Table 2. Participants' Sociodemographic Characteristics.

Characteristics	
Mean age (years)	44 (SD = 8.8)
Gender (n)	
Female	14
Male	2
Marital status (n)	
Single	2
Separated	2
Married	7
Widowed	1
Free union	3
Civil union	1
With children (n)	
Yes	13
No	3
Trained in counseling (n)	
Yes	4
No	12
Mean years of nursing experience	18.9 (SD = 10)
Means years of hemodialysis experience	11 (SD = 6.8)
Mean full-time equivalent percentage	77.8 (SD = 17.2)

Caring practice was strengthened. The 16 nurses asserted that caring practice was strengthened following the educational intervention. This first general category broke down into five subcategories: (1) patient-centered practice was strengthened; (2) importance of relational care was highlighted; (3) listening attitudes were strengthened; (4) patient well-being became overarching priority; and (5) quality of relationship with patients improved.

Patient-centered practice was strengthened. Following educational intervention. This was a general subcategory. All of the participants indicated that they were more focused on the patients and their needs, both physical and emotional. Five nurses talked about caring-based patient management being reinforced in their daily practice. Four nurses also mentioned a better capacity to put themselves in the patient's shoes by demonstrating empathy: *"I realized how much it's really important to share and exchange with patients, to show them that we hear, that we understand things from their point of view as well"* (P08).

Importance of relational care was highlighted. This second subcategory was typical (mentioned by 14 nurses). Three nurses indicated that exchanges with patients constituted care on a par with technical tasks. According to three nurses, the educational intervention also served to legitimize a style of patient management that looked beyond the physical dimension to focus also on the emotional needs and experiences of patients. One nurse stated that caring-based patient management could help HD patients give new meaning to their lives despite their chronic condition.

Listening attitudes were strengthened. This was a general subcategory touched on by all participants. Twelve nurses mentioned an increase in the frequency of their listening and being-there attitudes towards patients: "*Now, we listen to patients more actively, we're more mindful of the issue of wellbeing"* (P07). Six nurses gained a greater awareness of the fact that listening to patients more actively was conducive to problem solving and could at times suggest possible treatments and interventions. Four nurses indicated that they felt more confident about delving deeper into the concerns or needs expressed by their patients. One nurse expressed this confidence by exploring the private sphere of her patients a little more.

Patient wellbeing became overarching priority for nurses. This was a variant subcategory (six participants). Following the educational intervention, one nurse indicated that she took patient resources into greater consideration in order to promote patient wellbeing. She also sought solutions more jointly with patients to increase their comfort. Another nurse mentioned that she purposefully set out to provide positivity, serenity and benevolence to her patients with a view to optimizing their quality of life and wellbeing. She described the benefits of a discussion with a patient with

Table 3. Core Ideas Regarding Transformation of Clinical Nursing Practice
Category: Caring-Based Practice was Strengthened.

Category	Subcategories	Core ideas	No. of nurses[a]
Caring-based practice was strengthened *General category*	Patient-centered practice was strengthened *General subcategory*	1. Caring-based practice highlighted	3
		2. Strengthening of caring-based patient management helped in daily practice	5
		3. Exchanges with patients pre-intervention were trivial, now are valorized	1
		4. Increase capacity to put oneself in patient's shoes	4
		5. Openness to caring opportunities with persons cared for	2
		6. Centering of nursing care on person receiving treatment	7
		7. Increased sensitivity to opportunities for caring with persons cared for	2
		8. Impression thanks to intervention of having discovered new facets of patients in their care for years	2
		9. Significant transformation of practice thanks to educational intervention on caring	12
		10. Shift in stance made it possible to improve quality of nursing care	11
		11. Change in practice among colleagues	2
		12. Practice revitalized	1
		13. Increased humanism with patients in practice	1
		14. Better knowledge and awareness of emotional state of their patients	1
		15. Improved capacity to communicate with patients	1
		16. Shift in stance made it possible to improve patient safety	9
	Importance of relational care was highlighted *Typical subcategory*	1. Underscoring and importance of relational care	5
		2. Legitimation of relational care in nursing professional practice	6
		3. Exchanging with patients is care on par with technical tasks	3
		4. Reduced focus of technical tasks	4
		5. Raised awareness of importance of nurses providing emotional support to patients	5
		6. Greeting, approach and communication focused more on emotional state and needs of patient	10
		7. Helping patients experience dialysis well physically but also emotionally is really good thing	3
		8. Observing and taking account of patient non-verbal language can point to possible solutions	2
		9. Caring and carative factors help nurses enable patients to find meaning again in context of chronic condition	1
		10. Moments of caring cannot be quantified but improve quality of relationship and patient management	1
		11. Technical tasks are easy to master, but if relational skills are lacking, nurse is not good nurse	1
		12. Underscoring importance of how patients are greeted at first sessions and on daily basis	1
		13. Allowing self to take more time for relational care with patients	1
	Active listening attitudes were strengthened *General subcategory*	1. Increase in active listening of and being there for patients	12
		2. Importance of exploring patients' problems	6
		3. Importance of actively listening to patients with needs	8
		4. Gained awareness that not actively listening to patient stalls situation	1
		5. Listening more actively to patients facilitates solving their problems and provides leads	6
		6. Increased legitimacy of probing further with patients	4

(continued)

Table 3. Continued.

Category	Subcategories	Core ideas	No. of nurses[a]
		7. More time spent discussing with patients	5
		8. Going back to patients to actively listen to them when no longer hooked up to dialysis machine	1
	Patient wellbeing became overarching priority *Variant subcategory*	1. Refocusing priorities in practice	2
		2. Patient wellbeing became priority	2
		3. New desire to bring positivity, serenity and benevolence to patients	1
		4. Increased analysis and consideration of patient resources to promote their wellbeing	1
		5. Greater search for solutions to increase patient comfort	1
		6. Better emotional management when patients are aggressive	1
		7. Better management of patient aggressiveness thanks to resource assessment tool	1
		8. Better management of conflicts with patients	3
	Quality of relationship with patients improved *Typical subcategory*	1. Relationship with patient deepened	4
		2. Closer proximity with patients	3
		3. More time spent with patients	6
		4. Greater flexibility and more time spent giving explanations to patients	2
		5. Desire to find solutions with patients for greater intimacy	2

[a]Number of nurses who touched upon core idea at least once during interview.

whom she took the time to have a more heart-to-heart talk: *"I took the time to have a real conversation with her. I clearly drew on the intervention that I had received for that. I had never seen her smile before, she opened up a little more (…) that's all I wanted"* (P02).

Quality of relationship with patients improved. This was a typical subcategory (12 nurses). Three nurses stated that they developed a closer relationship with patients and four mentioned that bonds were deepened. Two nurses said that they created an intimate space facilitating a time for discussing and exchanging with HD patients where solutions could emerge in response to their needs. This improved the quality of the relationship with their patients and fostered trust between patients and nurses. Table 3 summarizes the core ideas obtained for this first category.

New practices emerged. This second general category evidenced that new professional practices emerged following delivery of the educational intervention. Three subcategories were identified: (1) new interventions were being planned or had been initiated; (2) a new perspective and a common language emerged; and (3) self-reflection and reflection on personal practice emerged.

New interventions planned or initiated. This was a typical subcategory (11 nurses). Following the educational intervention, the nurses in some HD centers undertook several initiatives to enrich their practice. Four nurses mentioned reporting on the emotional state of patients at the weekly meeting whereas, before, they used to report solely on physical health parameters. Two nurses indicated that time spent delivering relational care was now entered in the computerized system, which provided a trail and allowed monitoring the emotional state of each patient alongside their physical health indicators. Similarly, in one HD unit, nurses set up a reference nurse system whereby each patient would be assigned a nurse who would serve as the contact and point of reference for them to ensure that treatment and care was more personalized and better adapted to their needs. Three nurses mentioned increased use of humor. One of these had this to say: *"Laughing with them, it's that simple! (…) Everything that's above and beyond the nurse's technical tasks, and it begins the moment you treat the other as a person"* (P16).

New perspective and common language emerged. This was a typical subcategory (nine nurses). Three nurses pointed out a shift in how they looked at their clinical practice. They perceived their clinical practice as making more sense the moment it comprised a human dimension and not solely a technical one. One nurse specified that this shift in how they looked at patients and their practice had the effect of reinforcing their motivation at work: *"For me, I think I feel more motivated, that's for sure, more motivated to take things differently, to look at them with different eyes"* (P04).

Seven nurses described the fact that the educational intervention gave them a new language for exchanging among themselves that cast fresh light on their daily practice. What's more, one nurse pointed out that this new common language attributed greater legitimacy to their practice: *"I*

Table 4. Core Ideas Regarding Transformation of Clinical Nursing Practice
Category: New Practices Emerged.

Category	Subcategory	Core ideas	No. of nurses[a]
New practices emerged *General category*	New interventions were planned or initiated *Typical subcategory*	1. Reporting on emotional state of patients at daily huddle	4
		2. Implementing a reference nurse system for patients	1
		3. Ongoing development of a pre-dialysis meeting	1
		4. Improving technical specifications to reduce stress for nurses and patients	1
		5. Increasing use of humor with patients	3
		6. Increasing physical contact with patients	1
		7. Intervention allowed setting up psychological monitoring by team of patient causing problems	1
		8. Self-monitoring and reminders to practice caring with humor and benevolence	2
		9. Moments of caring noted in computerized system	2
		10. Implementation of huddle to discuss state of patients	1
		11. Desire to create a new computerized support to keep track of life history of patients and assess their resources	1
	New perspective and common language emerged *Typical subcategory*	1. New language for their practice	7
		2. Shift in perspective on their clinical practice	3
		3. Shift in perspective on patients	2
		4. Results and common language valorize nursing practice	2
		5. New language for their practice fosters self-awareness	1
	Self-reflection and reflection on personal practice emerged *Typical subcategory*	1. Strengthening of reflection to improve patient management	7
		2. Nursing practice is not innate but the result of acquired knowledge, know-how and learning	1
		3. Higher awareness of importance of caring in clinical practice	4
		4. Higher awareness of social importance of hemodialysis for patients	4
		5. Caring entails honesty and positivity	1
		6. Humanism is basis of nursing profession	3
		7. Importance of knowing to self in order to help patients better	3
		8. Strengthening of reflective practice following intervention	5
		9. Reflective space around problem patients beneficial	2

[a]Number of nurses who touched upon the core idea at least once during interview.

thought the training was excellent, it made it possible for us to name things, to give all of that legitimacy" (P11). This new common language also brought out the singularity of the work performed by nurses and fostered a new-found awareness of the value of their services: *"I don't just chat with patients. It has a purpose, we have words we can use to ask questions, and it valorizes your practice and your role. We've gained a higher awareness of the work that we do on an everyday basis"* (P02).

Self-reflection and reflection on personal practice emerged. This was a typical subcategory touched up by 12 nurses. Seven nurses stated that they strengthened their level of self-reflection in their daily practice. This helped improve their patient management. Four nurses also mentioned gaining awareness of the usefulness of a caring approach in clinical practice: *"I'm tempted to say that this training helped me gain a permanent awareness of my patients"* (P09). One nurse also gained awareness of the fact that nursing practice was not innate but derived from different types of knowledge and learning: *"No, it isn't something you do instinctually. You do it because you've gone through training, you've acquired skills, some values are buried deep inside you"* (P05).

This core idea related to the previous subcategory. Using precise terminology to define the relational care delivered to patients valorized the clinical practice of nurses. Table 4 summarizes the results obtained for this second category.

Limitations appeared. This theme constituted a rare category mentioned by two of the 16 nurse participants. One subcategory was defined: *No perceived change in practice* following the educational intervention. Both nurses mentioned that there was no change in their practice following the educational intervention, making this a rare subcategory. One asserted that she was already focused on her patients and listened to them actively. A second nurse was not able to say for

Table 5. Core Ideas Regarding Transformation of Clinical Nursing Practice
Category: Limitations Appeared.

Category	Subcategories	Core ideas	No. of nurses[a]
Limitations appeared *Rare category*	No perceived change in practice following educational intervention *Rare subcategory*	1. No change in practice	2
		2. No transformation because already centered on patients	1
		3. Self-reflects on potential changes related to intervention	1
		4. No change in practice because active listening integral part of work	1

[a]Number of nurses who touched upon core idea at least once during interview.

sure whether certain changes were linked to having received the intervention or to other external factors. Table 5 summarizes the results obtained for this third category.

Discussion

The aim of this study was to explore the perception of HD nurses regarding changes to their clinical practice after receiving an educational intervention intended to strengthen their caring attitudes and behaviors towards patients.

As was the case with nursing interventions in previous studies (see Cossette et al., 2019, for a review), our intervention was greatly appreciated by almost all of the nurses in our sample, who described it as a useful means to develop their professional expertize. Unlike most previous studies (Cossette et al., 2019), our study was able to describe how the attitudes and behaviors of nurses changed following an intervention or, perhaps more accurately, how they narrated this change. This said, there is no need to underplay the role of nurses' perceptions given that they are filtered by their attitudes and values, which constitute the premise of any change in behavior and which were the direct targets of our intervention. The nurses stated that their caring-based practice was reinforced.

Our results showed that all of the nurses perceived a re-centering of their practice on patients following the educational intervention. They mentioned, in particular, the fact that they gave greater consideration to the needs and concerns of their patients. This constitutes a central result considering the numerous benefits to be had from implementing a patient-centered practice that integrates both physical and relational care in treatments constitutes the very essence of a holistic approach. In her Theory of Human Caring, Watson presents an approach that takes account of the uniqueness and individuality of each patient (Caruso et al., 2008; Watson, 2012). Instead of staying focused solely on physical symptoms, health professionals take into consideration the patient's personal values, singularity and preferences and thus demonstrate empathy. Consequently, a shift occurs from a practice focused nearly exclusively on technical aspects of care to a practice centered on actively listening to patients. This is a key result, particularly in HD units where the tech-intensive care provided can easily become robotic (Bennett, 2011). As HD patients sometimes get the feeling that they have lost control of their life, it is critical for them not to be considered as passive recipients of care but rather as responsible agents who are listened to and who are capable of making decisions. Being more attentive to the situation as it is experienced by patients leads to shared decision making, which takes account of each person's unique situation (Coulter & Collins, 2011; Deegan & Drake, 2006; Deegan et al., 2008; Finderup et al., 2020; Robinski et al., 2016). Systematic reviews have shown that when care providers and patients collaborate to identify problems and needs, define objectives and make decisions jointly, patients are more satisfied with and have greater trust in their care providers, and their symptoms diminish more rapidly (Rao et al., 2007). When patients feel responsible for their treatment, they are more invested in the treatment, and they may also propose things that healthcare providers would never have thought of (Deegan et al., 2008). Nevertheless, to implement a solid partnership between patients and healthcare professionals, the latter must have an attitude that allows patients to enter into this kind of relationship. In the context of HD units, where patients are strictly dependent on a very technical life-saving treatment, the power dynamics are unbalanced in favor of healthcare professionals. Consequently, the attitudes and behaviors of nurses are critical to creating an environment that fosters patient empowerment. In addition to improving the quality of healthcare services, a better relationship with patients also had a positive effect on nurses' quality of working life. A better quality NPR allowed them to rediscover the meaning of their profession by forging a stronger bond with their patients. This corresponds to the essence of the nursing profession (Nightingale, 1974). Delivery of this educational intervention helped nurses reconnect with the essence of the nursing profession, that is, restore the caring relationship as a fundamental element in the quality of the relationship and as a central dimension of care.

Another element emphasized by our results is the emergence of new practices. The educational intervention

helped mobilize nurses, pushing them to undertake initiatives and implement new interventions in their clinical practice, which allowed generating a process of creativity in daily care. This corresponds to the sixth carative factor described by Watson in her Theory of Human Caring, that is, a creative caring process geared to problem solving (Caruso et al., 2008; Watson, 2012). This process was fostered by the emergence of a new perspective and a common language. The creation of a common language allowed structuring nursing thought and giving more visibility to nursing care. Despite the small number of hours of training received, the nurses managed to acquire within their practice a common language and terminology. By defining its language, the profession acquires structure and reveals its identity (Allen et al., 2007). It steps out of the shadows by naming what it does in its specific field, such as relational care. The emergence of a new language is strictly connected with the emergence of self-reflection and reflection on professional practice. The nurses stated that strengthening their reflection on their professional practice served to improve the quality of patient management. Stepping back from their clinical practice to examine it and using a clearly defined terminology for the relational care that they provide patients valorizes their clinical practice as nurses and allows them to gain awareness both of the value of their role and of their professional standing. This, in turn, helps promote quality of care and patient safety. New practices, a new language, and a new approach are all hints that the change introduced by our intervention was structural rather than superficial.

Nevertheless, this change was not unanimous: Two nurses declared that they perceived no change in their practices following intervention. Even if only two people mentioned this element, it must not be downplayed. It may suggest that the intervention needs to be tweaked, enriched and refined. As this was the first time that the intervention was delivered to a large population, it will no doubt undergo further development. However, the fact that only a small minority of people were insensitive to the intervention may also be a mark of quality. Our intervention demands a deep reflection on nurses' attitudes and behaviors. If an intervention is positively welcomed by every participant, this may indicate that it is too superficial. An intervention that demands little change can be easily accepted by everyone, whereas an intervention that seeks to bring about a deep restructuring of nurses' expertize may not sit well with anyone. As different people have different values and principles, it would take an impossible degree of personalization for an intervention to suit every situation.

Strengths and Limitations

Generally speaking, the rarity of negative and neutral responses was surprising and might reflect the presence of a social desirability bias. The desire to come across in a positive light might have influenced the expression of opinions (Butori & Parguel, 2010). However, the fact that the educational intervention was delivered according to plan is consistent with the fact that the participants had a positive opinion of it. The generally positive feedback provided by participants, too, was consistent with what they experienced during the training sessions.

One last limitation that must be cited is the absence of patient interviews. The patients' perspective would have been useful to corroborate or reject our results. However, as our study focused on nurses and how their perspective changed after the educational intervention, we preferred to delve deeper, if somewhat more narrowly, on this phenomenon.

Implications for Practice

Dehumanizing practices tend to emerge in care units where the level of technicity is high, such as HD units. The scientific literature has clearly demonstrated and confirmed the presence of such practices owing, on the one hand, to heavier workloads imposed in the name of economic profitability and, on the other, to the progressive increase in the use of technology in medical treatment and patient care (Cuchetti & Grace, 2020; Needleman, 2008; Sainsaulieu, 2003; Wilson et al., 2019). The benefits of a caring patient-centered practice have been clearly demonstrated in empirical research (Cara et al., 2011; Duffy & Hoskins, 2003; Lee et al., 2008; O'Reilly, 2007; Swanson, 2013). Also, qualitative studies of interventions to strengthen caring practices with HD patients are extremely rare, if not nonexistent (Wei et al., 2019). It is essential to build knowledge and gain an understanding of the key factors that help increase the humanization of care in order to improve quality of care and promote patient safety and wellbeing. The views expressed in the course of 16 interviews corroborate the fact that our educational intervention brought about changes to practice in the eyes of the nurses who participated in the study.

Conclusion

The nurses interviewed in this study confirmed the validity of the method and contents of the educational intervention that they received. Our results show that, following an intervention that lasted 14 h in all, the participating nurses perceived a real change in their clinical practice in terms of providing more caring and patient-centered care.

In their opinion, the intervention helped reinforce their caring practice by centering practice on the patient, valorizing relational care, strengthening listening attitudes, making patient wellbeing their overarching priority and, finally, improving the quality of the relationship with HD patients. The intervention also mobilized nurses given that new interventions were implemented in their clinical practice, a new perspective and common language was adopted and, finally, self-reflection and reflection on professional practice

emerged. The nurses pointed out few limitations following the educational intervention. The intervention hit its targets: It contributed to reconfigure HD care as caring by reminding participants of the nursing profession's deep meaning and introduced new concepts to support how nurses perceived their work. Nurses not only felt and acted according to caring principles, they also mastered concepts and a language to efficiently describe, communicate, and legitimize what they were doing. In times of crisis where the issue of the humanization of nursing care is front and center, this professional development activity may allow strengthening caring practice. This sort of practice needs to be developed within different care units in order to guarantee and foster quality of care and patient safety.

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Ethical Approval

This study was submitted for approval to the Canton of Vaud Research Ethics Board pursuant to Swiss federal law respecting human research. Ethical clearance was granted (No. 2017-00946). Every participant provided informed written consent ahead of the interview. Participants were advised in writing and verbally that they were free to withdraw from the study at any time and were assured that their participation was anonymous.

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