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Self-Compassion and Perceived Readiness for Practice Among Baccalaureate Nursing Students: A Mixed-Methods Study

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SELF-COMPASSION AND PERCEIVED READINESS FOR PRACTICE AMONG BACCALAUREATE NURSING STUDENTS: A MIXED-METHODS STUDY

by

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ABSTRACT

There is increasing concern about how nursing students' psychological health will impact their future nursing practice. The COVID-19 pandemic has enhanced these concerns. Nurse educators are being challenged with preparing nursing students to provide compassionate, patient-centered care despite the stress and psychological challenges of today's healthcare environment. Self-compassion is a practice of mindfulness, self-kindness, and common humanity which positively influences and predicts psychological health. The purpose of this study was to explore the relationship between self-compassion and perceived readiness for professional practice among undergraduate nursing students.

A convergent mixed-method design utilizing correlational and directed content analyses explored this relationship. The sample consisted of 82 senior nursing students from baccalaureate programs in the Northeastern Region of the United States. Participants completed an online survey consisting of a demographic questionnaire, the Self-Compassion Scale Short Form (SCS-SF), and the Casey Fink Readiness for Practice Survey ©2008. Eighteen of the participants were also interviewed. Results indicated that self-compassion and support systems positively influence perceived readiness. The findings promote psychological health as a component of readiness for professional practice and the incorporation of self-compassion development into nursing curriculum.

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DEDICATION

With heartfelt gratitude, I dedicate this dissertation to my family. To my husband Nick for your endless love, encouragement, and support. To my children Avery and Henry for making my heart smile and bringing me joy every day. To my furbaby Jaco for never leaving my side on those late nights. To my parents and sisters for always being my biggest fans. You are my world, and I couldn't have done this without all of you.

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LIST OF ABBREVIATIONS

AACN	American Association of Colleges of Nurses
BSN	Bachelor of Science in Nursing
CDC	Center for Disease Control
IRB	Institutional Review Board
NCSBN	National Council of State Boards of Nursing, Inc.
NLN	National League for Nursing
SCS-SF	Self-Compassion Scale Short Form
USM	The University of Southern Mississippi
WHO	World Health Organization

CHAPTER I - INTRODUCTION

Current nursing practice can be stressful and challenging to nurses' psychological health which can lead to poor healthcare outcomes. The COVID-19 (coronavirus disease) pandemic has enhanced these hardships for nurses and nursing students (Aslan & Pekince, 2021). In an academic setting, nursing students have expressed concern for meeting these challenges upon entering professional practice (Luo et al., 2019; Reeve et al., 2013). However, researchers have found that self-compassion is a predictor of positive psychological health which ameliorates the challenges of working in demanding healthcare settings (Luo et al., 2019; Mathad & Pradham, 2017; Neely et al., 2009; Neff et al., 2007; Shin & Lim, 2019).

Psychological health concerns such as stress, compassion fatigue, and burnout have become common language in nursing and healthcare as they have shown to negatively impact healthcare outcomes (Kelly & Tyson, 2016; Luo et al., 2019; McVicar et al., 2021). Nurses are expected to provide safe, effective, person-centered compassionate care. Person-centered care is the ability to provide compassionate care and to connect with others through intentional presence and ways of knowing (American Association of Colleges of Nursing [AACN], 2021). Compassionate care requires acknowledging suffering in others and taking action to alleviate it (Curtis, 2014). Psychological health is comprised of emotional, mental, and social well-being; it influences how one thinks, feels, and acts, determines how stress is processed and affects one's ability to relate to others (Fong & Loi, 2016). As nursing practice evolves, it is becoming increasingly evident that nurses' psychological health must be addressed to ensure safe, effective, person-centered compassionate nursing care.

Nursing students have high levels of perceived stress, anxiety, and depression (Luo et al., 2019; Reeve et al., 2013) that may be attributed to many factors such as academic workload, clinical practice experiences, competing priorities, inadequate social support, ineffective coping skills and more recently the impact of the pandemic on nursing education (Aslan & Pekince, 2021; Fong & Loi, 2016; Luo et al., 2019; Reeve et al., 2013; Senturk & Dogan, 2018). Along with facing these psychological challenges, nursing students have expressed concern for maintaining the ability to provide continuous compassionate care (Curtis, 2014). Addressing these challenges and concerns of students enrolled in nursing education programs is imperative for developing professional nurses that are capable of providing compassionate, person-centered care. Several studies suggest promoting self-compassion in nursing students to address these issues (Luo et al., 2019; Mathad & Pradham, 2017; Senyuva et al., 2014; Shin & Lim, 2019).

Self-compassion is the practice of being compassionate towards oneself and involves a practice of mindfulness, self-kindness, and consideration of common humanity (Neff, 2003b; Neff et al., 2007). In addition, self-compassion was found to be a precursor to intentional presence and correlated with the compassionate care delivered by registered nurses (Neff, 2003b; Watson, 2008). Research has shown that self-compassion promotes psychological health by reducing the effects of stress, anxiety, depression, compassion fatigue, and burnout (Luo et al., 2019; Mathad & Pradham, 2017; Neff, 2003b; Neff et al., 2020; Shin & Lim, 2019; Sinclari & Wallston, 2004). In this study, Watson's theory of human caring was used to provide a framework that emphasized the importance of self-compassion in professional nursing practice.

Problem Statement

There is increasing concern about how nursing students' psychological health will impact their future nursing practice. In fact, researchers assert that further support is needed during nursing education to address these issues (Curtis, 2014; Luo et al., 2019; Reeve et al., 2013; Senturk & Dogan, 2018). Self-compassion positively influences and predicts psychological health (Fong & Loi, 2016; Neely et al., 2009; Neff et al., 2007; Shin & Lim, 2019) which influences undergraduate student perceptions of readiness for career transition and the assumption of a professional role (Yang & Gysbers, 2007), indicating that self-compassion will influence readiness for professional practice in nursing students. Currently, effects of capstone assignments and perceptions of skills competence, confidence, and imposterism on readiness to practice have been explored in the literature (Casey et al., 2011; Christensen et al., 2016; Guner, 2014; Usher et al., 2015), however, there is little research on how psychological health or self-compassion affects readiness to practice among undergraduate nursing students. Therefore, the results of this study will add to the body of literature on factors that influence readiness to practice and provide guidance for nursing educators as they identify areas of needed support.

Purpose

The purpose of this mixed-method study was to explore the relationship between self-compassion and perceived readiness for practice among undergraduate senior nursing students in baccalaureate programs. Each component of self-compassion predicts a dimension of psychological health; mindfulness predicts emotional well-being, self-kindness predicts mental well-being and common humanity predicts social well-being

(Fong & Loi, 2016). Therefore, examining the relationship between self-compassion and perceived readiness for practice also predicts the influence of psychological health on perceived readiness for practice. Based on the literature supporting self-compassion as a predictor, promoter, and protector of psychological health (Fong & Loi, 2016; Luo et al., 2019; Neff et al., 2007), self-compassion is considered a proxy for psychological health in this study.

According to Creswell and Plano Clark (2018), a mixed-method design provides a more thorough understanding of the research problem. A thorough understanding of the relationship between self-compassion and perceptions of readiness for professional nursing practice provides insight as to how nursing students' psychological health may potentially impact their future nursing practice and determines if further psychological support during nursing education is of benefit. In this study, the quantitative data established the relationship between self-compassion and perceived readiness for practice, whereas the qualitative data provided context and perception of that relationship.

Research Questions

This mixed-methods study embraces the worldview of pragmatism. Pragmatism values both objective and subjective data to best address the research problem and apply the results to practice (Creswell & Plano Clark, 2018). When developing research questions for a mixed-methods design of this worldview it is important to consider both data sets and how they are integrated (Creswell & Plano Clark, 2018). In this study, nursing student perceptions stood to confirm or deny the quantitative results which provided a more thorough understanding of the relationship being explored and insight as

to how to best address the research problem in nursing education practice. The following questions were developed for the study:

1. What are the perceptions of practicing self-compassion and its role in readiness for professional practice among nursing students?
2. What is the relationship between nursing students' self-compassion and perceived readiness to practice?
3. To what extent do students' perceptions of self-compassion confirm outcome data on a readiness to practice measure?

Hypotheses

The research hypothesis for the quantitative portion of this study was that self-compassion positively influences perceived readiness for professional practice in nursing students.

Research Objectives

The objectives of this research study were:

1. To explore perceptions of practicing self-compassion and its role in perceived readiness for practice.
2. To identify the relationship between self-compassion and perceived readiness for practice in nursing students.
3. To understand any impact that self-compassion, as a positive influence and predictor of psychological health, has on nursing students' perceptions of readiness for practice.

Theoretical Framework

The theory of human caring (Watson, 1985, 2008) provided the conceptual framework for this study. It was used to explore and identify the relationship between self-compassion and readiness for professional nursing practice in baccalaureate nursing students. Watson's (2008) theory focuses on the importance of providing compassionate care for the self when caring for others, indicating that caring for the self and caring for others are interdependent. According to Watson's (2008) theory, caring for the self involves self-kindness, mindfulness, and equanimity. Watson (2008) also suggests that caring occurs at a deeper level of humanity where everyone is connected. Self-kindness, mindfulness, and connected humanity are reflective of the components of self-compassion (Neff, 2003b) thereby signifying that providing compassionate nursing care requires a practice of self-compassion.

The theory of human caring (Watson, 2008) identifies 10 Caritas Processes as the components of compassionate care (see Appendix A). Caritas Processes are meant to be a theoretical guide to compassionate caring practice (Watson, 2008). Each process reflects a way of being rather than a skill to develop. This study focused on the first, second, third, and sixth caritas processes as they best reflect the concept of self-compassion and its value in providing person-centered compassionate care. The first, second, third, and sixth caritas processes are:

1. Sustaining humanistic-altruistic values by practice of loving-kindness, compassion, and equanimity with self/others.
2. Being authentically present, enabling faith/hope/belief system; honoring subjective inner, life-world of self/others.

3. Being sensitive to self and others by cultivating own spiritual practices; beyond ego-self to transpersonal presence
6. Creatively problem-solving-'solution-seeking' through caring process; full use of self and artistry of caring-healing practices via use of all ways of knowing/being/doing/becoming (Watson Caring Science Institute, 2021).

Caritas 1-3 best embody the components of self-compassion. The characteristics of Caritas 1 relate to self-kindness; intentionally practicing loving-kindness with the self allows for meaningful, compassionate caring (Watson, 2008). Embracing Caritas 1 requires setting an intention to practice loving-kindness with the self and others no matter the circumstances and upholding inner balance through the release of encounters and experiences with gratitude for the wisdom gained from them (Sitzman & Watson, 2014). Caritas 2 and Caritas 3 relate to mindfulness and common humanity; intentionally being present and aware of the needs of the self and others, understanding one's place within humanity, and nurturing growth during life's journey (Watson, 2008). Embracing Caritas 2 requires openness to, and mindfulness of others hopes and beliefs; honoring each moment and the wisdom to be gained from it (Sitzman & Watson, 2014). Embracing Caritas 3 requires the cultivation of compassionate curiosity; seeking a deeper understanding of one's inner wisdom and being open to genuine connection with others and their experiences (Sitzman & Watson, 2014). Caritas 6 exemplifies the AACN (2021) recommendations for providing person-centered compassionate care in professional nursing practice; using all ways of knowing to make caring practice decisions (Watson, 2008). Embracing Caritas 6 requires one to provide care with a holistic perspective;

utilizing inner wisdom, mindful awareness, and connection with others to address concerns and make caring decisions (Sitzman & Watson, 2014).

Using the selected caritas for this study, self-compassion, the independent variable, would influence readiness for professional practice, the dependent variable, because self-compassion practice indicates multifaceted ways of knowing and provision of compassionate care. Taking care of oneself and increasing understanding of one's internal knowing increases one's ability for caring (Watson, 2008). Refer to Figure 1 for an illustration of the relationship among self-compassion, and readiness for practice.

Figure 1. Theoretical Framework

Note: The theoretical relationship among self-compassion and readiness for practice presents as a ripple effect.

Theoretical Definitions

Theoretical definitions for this study are:

1. *Psychological Health* – Emotional, mental, and social well-being (Center for Disease Control [CDC], 2020).
2. *Stress* – The perception of psychological imbalance or pressure (Durand-Bush et al., 2015).
3. *Compassion Fatigue* – The inability to provide compassionate care due to the sustained enduring and holding on to the stress of caring for those that are suffering (Kelly & Tyson, 2016; McVicar et al., 2021).
4. *Burnout* – Unmanaged workplace stress that can result in physical and mental manifestations for the healthcare worker as well as a reduced professional competence (World Health Organization [WHO], 2019).
5. *Self-Compassion* - Being compassionate towards oneself; practicing self-awareness of one's own perceived suffering, and being mindful to withhold judgment, and understand that suffering is part of the human experience (Neff, 2003b).
6. *Compassionate Care* – Nursing care that focuses on connecting to others as human beings through acknowledging their suffering and taking action to alleviate it (AACN, 2021; Curtis, 2014).
7. *Person-Centered Care* – Nursing care that focuses on the individual in their entirety through "holistic, individualized, just, respectful, compassionate, coordinated, evidence-based, and developmentally appropriate" (AACN, 2021, p. 11).

8. *Intentional Presence* – Deliberately being in the moment (Watson, 2008).
9. *Ways of Knowing* –Personal, empirical, ethical, and aesthetic knowledge (Carper, 1978).
10. *Readiness for Practice* – The perception of preparedness for taking on the role of a professional nurse (Casey et al., 2011).
11. *Coronavirus Disease (COVID-19) Pandemic* – a disease caused by the SARS-CoV2 virus that spread worldwide beginning in December 2019 (WHO, 2021).

Assumptions, Limitations, and Delimitations

Assumptions

The first assumption of this study was that nursing students' psychological health will impact their future practice. Poor psychological health and stress impede nursing students from becoming qualified future caregivers (Luo et al., 2019; Senturk & Dogan, 2018). The second assumption was that nursing students practice and understand the concept of self-compassion. Several studies have explored the concept of self-compassion in college students, demonstrating that self-compassion is an innate, ever-changing practice capable of intentional enhancement (Fong & Loi, 2016; Luo et al., 2019; Neely et al., 2009; Neff et al., 2007). The final assumption of this study was that nursing students' self-compassion practice will influence their perceptions of readiness for practice. Neff (2003b) suggests that self-compassion increases knowledge and understanding of one's limitations; therefore, supporting self-appraisal accuracy.

Limitations

The limitations of this study were sample type and the convergent design. A convenience sample relies on participants that are available at the time which may not accurately reflect the entire population of senior nursing students in baccalaureate programs within the United States (Gray et al., 2017). The convergent design reflects a single point in time, unequal samples, and risks failing to resolve disconfirming results (Creswell & Plano Clark, 2018). Strategies to minimize these concerns such as specifying the sample sizes for both data sets and engaging in understanding of any disconfirming results was performed (Creswell & Plano Clark, 2018).

Delimitations

The delimitations of this study were the sample population and the survey length. The sample population in this research was restricted to baccalaureate nursing students in their senior year in the Northeastern Region of the United States. While this sample population reduced potential bias of the convenience sampling, it reduced generalizability for all nursing students (Gray et al., 2017). The combined surveys consisted of a total of 37 questions and online interviews were requested which *we*re expected to take 30-60 minutes. The length of surveys and time commitment of the interviews may have been considered burdensome to the participants given their academic workload and other life stressors (Luo et al., 2019; Senturk & Dogan, 2018).

Significance of the Study

The AACN (2021), has recently charged nursing educators with producing entry-level nurses that are competent in providing compassionate, person-centered care. A growing body of literature shows that nursing students are concerned in their ability to provide sustainable compassionate care (Curtis, 2014; McVicar et al., 2021) and that

there is a mismatch in perceptions of readiness for practice between nursing students and new graduate nurses (Casey et al., 2011; Casey et. al., 2004; Ho et al., 2021; Jarden et al., 2021). The COVID-19 pandemic has negatively impacted nursing students' perceived stress (Aslan & Pekince, 2021) which affects psychological health (Fong & Loi, 2016) and the ability to provide compassionate care (Kelly & Tyson, 2016). Psychological health in nurses has shown to impact the ability to provide compassionate, person-centered care (Kelly & Tyson, 2016). Self-compassion is essential to providing compassionate care (Neff, 2003b; Watson, 2008) and has proven to predict psychological health in students (Fong & Loi, 2016; Shin & Lim, 2019). Therefore, research suggests that nursing educators need to address these gaps in the literature on the impact of self-compassion on readiness to practice (Luo, et al., 2019; Reeve et al., 2013; Senturk & Dogan, 2018). Understanding self-compassion in nursing students as a predictor of psychological health further explores the support needed during their nursing education to prepare them to be competent as compassionate, person-centered caregivers.

Summary

Chapter I provided an overview of self-compassion as a predictor of positive psychological health, nursing student concerns of meeting the psychological challenges of professional practice, and the need to address these concerns during nursing education (Luo et al., 2019; Neff et al., 2007; Reeve et al., 2013; Shin & Lim, 2019). The relationship of self-compassion and perceived readiness for professional practice using the theory of human caring as a philosophical and ontological framework is explored in this study to provide an understanding of the support needed to address these concerns.

To foster professional nurses capable of providing compassionate, person-centered care it is essential that these challenges and concerns are addressed during nursing education.

CHAPTER II – REVIEW OF THE LITERATURE

Introduction

Nursing student readiness for professional practice is a continual concern in healthcare and among nursing educators (Casey et al., 2011; Christensen et al., 2016; Curtis, 2014). Adjusting to the professional role and providing compassionate, person-centered care safely and effectively is often accompanied by stressors that can influence one's psychological health (Casey et al., 2011; Fink et al., 2008; Ho et al., 2021; Jarden et al., 2021). Self-compassion is a positive self-attitude that promotes and predicts psychological health (Luo et al., 2019; Neff, 2003b; Neff et al., 2007; Shin & Lim, 2019). Using self-compassion as a proxy for psychological health, this study seeks to build from previous research and explore the connection between self-compassion, as a predictor of psychological health, in nursing students to their perceptions of readiness for practice.

A literature search for this study was conducted using the online databases CINAHL Complete, APA PsycInfo, Psychology and Behavioral Sciences Collection, Academic Search Premier, PubMed, and MEDLINE. Search criteria included peer-reviewed, full-text articles in English using combinations and variations of the keywords nursing students, student nurses, undergraduate nurses, or pre-registration nurses; self-compassion; compassionate care or compassionate nursing practice; readiness or preparedness for practice or transition; psychological health or well-being and ways of knowing. Articles concerning nursing students, self-compassion, psychological health, and compassionate care were reviewed. Studies investigating the relationship of self-compassion and/or psychological health and perceived readiness for practice in nursing students were not found in the literature. The major themes of this review encircled the

variables of this study: self-compassion and readiness for professional nursing practice. Self-compassion themes included self-compassion as a psychological health determinant and defender, self-compassion as a compassionate, person-centered nursing care prerequisite, and methods of self-compassion development in nurses and nursing students. Readiness for professional nursing practice themes included student perceptions of readiness and competency and new nurse perceptions on meeting the expectations of professional practice.

The theoretical framework for this study, Watson's theory of human caring (2008), is supported by the literature. The mixed-methods design is intended to provide insight into how nursing students' self-compassion may impact their future nursing practice. To explore the theoretical foundation that self-compassion is a precursor to providing compassionate, person-centered care, articles on self-compassion as a predictor and protector of psychological health, the influence of self-compassion on providing compassionate, person-centered care, and student perceptions of readiness for professional practice were reviewed.

Self-Compassion

According to Neff (2003b), self-compassion stems from Eastern philosophy. However, it has been present in Western theory and research throughout the past few decades. Neff (2003b) further defined the concept of self-compassion as recognizing one's personal feelings of suffering and refraining from self-judgment thereby transforming perception and strengthening the ability to clearly control one's actions. Three components of self-compassion were identified:

(a) self-kindness—being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical

(b) common humanity—perceiving one's experiences as part of the larger human experience rather than seeing them as separating and isolating…

(c) mindfulness—holding painful thoughts and feelings in balanced awareness rather than over-identifying with them (p. 85).

These components are interconnected; each component enhances or encourages the other. Together they work to foster one's optimal health and functioning while enhancing compassion for others. To further highlight the significance of self-compassion as it relates to nursing and compassionate care the following subcategories will be discussed: self-compassion as a psychological health predictor and protector, methods of developing self-compassion, and self-compassion as a prerequisite for compassionate, person-centered nursing care.

Psychological Health Predictor and Protector

Several studies have provided justification supporting that self-compassion is a predictor of positive psychological health and well-being (Luo et al., 2019; Neff, 2003b; Neff et al., 2007; Shin & Lim, 2019) and is negatively associated with anxiety and depression acting as a defense against distress, burnout and compassion fatigue (Luo et al., 2019; Neff, 2003b). In 2003, Neff researched the concept of self-compassion as a healthy self-attitude with the objective of defining the process of self-compassion and theoretically exploring its possible relationship to other aspects of psychological health. Neff (2003b) compared self-compassion to passivity, self-pity, and self-esteem emphasizing that self-compassion is not solely self-focused rather it enhances one's

compassion for and connectedness with others. Based on the ability to provide equanimity and connection with humanity, Neff (2003b) concluded that increased self-compassion would benefit the psychological health of individuals and society. To further this research Neff et al. (2007) examined the relationship between self-compassion, positive psychological health, and personality traits in undergraduate students. Factors of positive psychological health such as agreeableness, conscientiousness. curiosity and exploration, happiness, wisdom, and personal initiative, were found to be significantly associated with self-compassion apart from personality traits concluding that self-compassion is a predictor of positive psychological health (Neff et al., 2007).

In 2016, Fong and Loi furthered this research by examining the mediating role of self-compassion in tertiary students' psychological health. Relations between self-compassion, satisfaction with life, flourishing, positive and negative affect, stress, burnout, depression, and social desirability were studied. Overall, self-compassion was strongly associated with lower distress levels and well-being and showed to hold a protective role in student psychological health. It was concluded that self-compassion supports positive psychological health in students and protects against negative affect, stress, burnout, and depression.

Luo et al. (2019) then examined the relationship of self-compassion in nursing students to perceived stress, anxiety, and depression. Self-compassion was found to be negatively associated with perceived stress and perceived stress was found to be positively associated with anxiety and depression, therefore, self-compassion was determined indirectly associated with anxiety and depression through perceived stress.

Thus, concluding that self-compassion promotes psychological health by reducing perceived stress and consequently anxiety and depression.

Shin and Lim (2019) continued by addressing the contribution of self-compassion to psychological health in undergraduate students. Relationships between the components of self-compassion and the three dimensions of positive psychological health were examined. Results showed that specific components of self-compassion related to specific dimensions of psychological health. Self-kindness was concluded to be a key predictor of positive psychological health as it was shown to significantly relate to all three dimensions, and was suggested to be the focus of future self-compassion-based strategies for improving psychological health.

Methods of Developing Self-Compassion

Supportive interventions aimed at developing self-compassion and reducing stress in healthcare professions have been explored in the literature. Mindfulness-based stress reduction (MBSR) and mind-body practices such as yoga and mindful meditation have shown to improve self-compassion (Bond, et al., 2013; Kabat-Zinn, 1990; Mathad et al., 2017). MBSR is a program that focuses on increasing one's ability to be present in the moment (Cohen-Katz et al., 2004; Kabat-Zinn, 1990). The majority of studies reviewed utilized MBSR, proving it to be an effective intervention for enhancing self-compassion and compassion towards others while reducing stress and burnout (Birnie et al., 2010; Cohen-Katz et al., 2004; Cohen-Katz et al., 2005; Kelly & Tyson, 2016; Mathad & Pradham, 2017).

In 2012, Neff and Germer piloted a mindful self-compassion training program in two studies. Both studies showed an increase in self-compassion and other aspects of

positive psychological health as well as decreased stress, anxiety, and depression that was maintained for a period of six months; the second study additionally noted an increase in compassion for others and an increase in sustainability to one year (Neff & Germer, 2013). Neff et al. (2020) later implemented a self-compassion program designed for healthcare professionals, once more conducting two studies to determine the efficacy of the program. The first study indicated an increase in self-compassion, compassion satisfaction, mindfulness, and a decrease in stress, anxiety, and depression (Neff et al., 2020). The second study confirmed the first study's findings and included significant associations with compassion for others, enhanced well-being, and reduced burnout, secondary traumatic stress, and emotional exhaustion (Neff et al., 2020). Neff et al. (2020) concluded that participation in the self-compassion program for healthcare professionals holds benefits to healthcare professionals' psychological well-being and compassionate practice.

It is worth noting that some studies identified favorable improvements in perceived stress and empathy, however, did not show significant results (Bond, et al., 2013; Mathad et al., 2017). Limitations such as generalizability, sample size, and timing were noted as possible causes (Bond, et al., 2013; Mathad et al., 2017). Overall, the literature recommends further examination of these interventions to increase self-compassion, reduce stress, and better support the psychological health of healthcare workers and healthcare students in practice.

Compassionate, Person-Centered Nursing Care Prerequisite

The literature supports that self-compassion is a precursor for providing sustainable compassionate, person-centered care (Curtis, 2014; Dalai Lama, 2000; Neff,

2003b; Neff et al., 2020; Watson, 2008; Wiklund Gustin & Wagner, 2013). Eastern philosophy maintains that one cannot be compassionate for others if one is not compassionate for the self (Dalai Lama, 2000). Watson (2008) further asserts that a nurse must be open, mindful, and able to reflect on of all one's thoughts and feelings in order to remain sensitive to others. Utilizing Watson's theory, Wiklund Gustin and Wagner (2013) concluded that compassionate care is not something a nurse does: it is intentional interconnected openness between a caregiver and care receiver. Neff et al. (2020) concluded that self-compassion allows for an understanding of suffering as part of the common humanity, therefore, "giving compassion to oneself in the act of caring for others is what actually allows [healthcare professionals] to sustain giving to others without burning out" (p. 15).

In 2020, Andrews et al. conducted a grounded theory study revealing that nurses do not perceive current nursing culture as promoting self-care and self-compassion. Nurses recognized that self-care and self-compassion lead to compassionate care giving, however, they felt that these actions were not easily attainable and that they needed permission to do them (Andrews et al., 2020). Self-care and self-compassion were regarded as coping strategies rather than practices (Andrews et al., 2020). Andrews et al. (2020) suggested that receiving permission earlier in their career development may assist in making self-care and self-compassion common practice in addition to supporting well-being and reducing stress. This suggestion is consistent with the aims of the literature previously discussed regarding methods of developing self-compassion in healthcare professionals and students to support their psychological well-being and compassionate practice.

Readiness for Professional Practice

The concept of readiness for practice in nursing has been in discussion for decades (Wolff, Regan et al., 2010). Wolff, Regan, Pesut, and Black (2010) sought to define the concept of readiness and found that it comprises of entry-level clinical competency, adaptability, and balance with an emphasis on the ability to provide safe care. It was also found that the meaning of readiness for practice is based on perception and greatly varies, therefore, there is a need for a shared understanding in order to better prepare and support new nurses for the transition to professional practice (Wolff, Regan et al., 2010; Wolff, Pesut et al., 2010).

According to Mirza et al. (2019), the concept of readiness for practice consists of three attributes clinical capability, cognitive capability, and professional capability. Clinical capability includes psychomotor skills, assessment, and care delivery. Cognitive capability includes competence, clinical reasoning and judgment, and situational awareness. Professional capability includes professional identity, self-esteem, self-worth, self-efficacy, and accountability. It is important to note that self-efficacy overlapped each of the other attributes. The authors note that this conceptual model is technical and does not take person-centered attributes, such as compassion, into account. As person-centered attributes have shown to improve quality care it was concluded that both technical and person-centered attributes must be taken into account when considering the concept of practice readiness, therefore, further research on person-centered attributes of practice readiness is warranted.

Gandhi et al. (2021) took this concept a step further exploring nurse and nursing student readiness from a psychological perspective. This study focused on psychological

preparedness for practice in light of the COVID-19 pandemic. Findings showed that self-efficacy, optimism, and resilience are indicative of psychological preparedness. Nursing students scored lower in these areas than practicing nurses. It was suggested that resilience and coping strategies be addressed to promote psychological preparedness in nursing students and thereby enhance readiness for practice. Gandhi et al. (2021) highlighted the fact that current nursing students are entering the profession during the COVID-19 pandemic and therefore, it is essential to include psychological preparedness when considering the concept of readiness for professional practice today. The remaining discussion will focus on student perceptions of readiness and competency, and meeting expectations.

Student Readiness and Competency

The literature establishes that senior nursing students generally perceive that they are ready for professional practice (Casey et al., 2011; Christensen et al., 2016; Guner, 2014; Usher et al., 2015), however, some studies presented a waiver in this perception pertaining to compassionate practice and the professional role (Christensen et al., 2016; Curtis, 2014). Casey et al. (2011), explored senior nursing students' perceptions of readiness for practice focusing on comfort/confidence levels regarding specific procedures and professional practice skills, and the senior practicum experience. Although clinical competency, knowledge, and role development were identified as some areas that could use improvement, students felt practice-ready (Casey et al., 2011). In a similar study, Gunner (2014), confirmed these findings additionally highlighting the gap between educational theory and clinical skills, and the role educational resources played in student perceptions of readiness. Usher et al. (2015) explored student perceptions of

readiness pertaining to a capstone project and although the capstone project did not prove significant, the study further validated previous findings and emphasized the importance of addressing these stressors to build confidence and competence prior to entering professional practice.

Student perceptions of professional identity and the emotional labor required for providing compassionate care have also been explored. In 2014, Curtis studied nursing student socialization in compassionate practice and found that students' emotional well-being impacted their engagement. Students revealed feelings of vulnerability and doubt in response to the discord between the professional ideal and the realities of compassionate practice (Curtis, 2014). Self-compassion strategies were recommended to enhance students' abilities to manage emotions and protect their well-being, therefore, impacting their future compassionate nursing practice (Curtis, 2014). Christensen et al. (2016), examined senior nursing students' feelings of imposter phenomenon or self-doubt in one's abilities and perceptions of readiness for practice. Again, students were found to generally perceive readiness, however, mild to moderate self-doubt was evident (Christensen et al., 2016). It was suggested that the intensity of these internal conflicts may be a result of variations in formal and informal components of the curriculum and that further research is needed to identify how to best support students regarding these issues (Christensen et al., 2016; Curtis, 2014).

Meeting Expectations

Research on the transition to practice experience has revealed an inconsistency in perceptions of student nurse readiness and new graduate nurses' confidence in meeting expectations of professional practice (Casey et al., 2004; Duchscher, 2009; Fink et al.,

2008; Ho et al., 2021; Rainbow & Steege, 2018). In 2004, Casey et al. identified stressors and challenges of new graduate nurses within the first year of professional practice as lack of confidence in skills and knowledge, peer and preceptor relationships, dependency, work environment, prioritization, and inter-disciplinary communication. Fink et al. (2008) furthered these findings adding that although some graduate nurses experience stressors beyond the first year, they are most prevalent in the first six months of practice. In 2009, Duchscher theoretically reinforced the need for more supportive measures during the first months of the student to new nurse transition in the transition shock theory: a preparatory theory regarding role transition and the role of nursing education and clinical employers.

Further, Rainbow and Steege (2018) examined understanding of the nursing role, self-compassion as a coping mechanism, perceived stress, burnout, and presenteeism, the practice of being present, in new nurses with 1-2 years of practice. Results showed high levels of stress, decreasing levels of self-compassion, the presence of burnout and presenteeism, and an inability to describe and thoroughly understand the role of the nurse. Ho et al. (2021) recently confirmed that transition shock is still occurring despite the efforts of nurse educators and clinical employers. The adaptation to independent holistic practice continues to leave new nurses feeling overwhelmed and stressed warranting further exploration into underlying reasons or sources contributing to feelings of unpreparedness in order to develop appropriate supportive measures (Ho et al., 2021).

The mismatch between student perceptions and new graduate perceptions of readiness for practice is evident. The increasingly complex care and stress levels of today's healthcare system has resulted in approximately 25% of new nurses leaving their

place of initial employment within their first year of practice (National Council of State Boards of Nursing [NCSBN], 2021). As psychological distress has shown to play a role in readiness for career transition (Yang & Gysbers, 2007), further exploration into practice readiness from a psychological health perspective in addition to the practical is essential in the hope of offsetting the source of this problem.

Theory of Human Caring

The theory of human caring (Watson, 1985, 2008) has been utilized as a framework in several studies exploring self-care, compassion development, and nursing practice. For example, studies have shown that self-care is an important component of emphasis in the concept of professional compassionate caring (Costello & Barron, 2017; Sitzman, 2007) and a nurse's ethical obligation (Linton & Koonmen, 2020). Additionally, self-compassion has been shown to be a way of being that directly influences one's ability to deeply connect with others to provide compassionate nursing practice (Wiklund Gustin & Wagner, 2013).

The theory of human caring has been used in course development to emphasize and foster professional, compassionate caring practice. Sitzman (2007) created a course for senior nursing students founded on Watson's theory that focused on the concept of professional caring. Self-care, caring relationships, leadership, and the environment were addressed (Sitzman, 2007). Costello and Barron (2017) utilized Watson' theory as a framework for an end-of-life course aimed at developing nursing students' abilities to provide compassionate care. The course emphasized reflective practice, self-care, and other caring-healing modalities. Both Sitzman (2007) and Costello and Barron (2017) found that by enhancing students' understanding of theory-based caring, students'

awareness of the complexity of caring and perception of the importance of committing to intentional caring practice to provide compassionate care was realized.

Wiklund Gustin and Wagner (2013) used Watson's theory for data interpretation when exploring clinical nursing educators' "understanding of self-compassion as a source to compassionate care" (p. 175). and found that, as previously mentioned, compassionate care is not only something the nurses provide but also a way of being, becoming, and belonging together in a moment of mutual vulnerability and dignity. Thus, concluding that self-compassion contributes to compassionate caring and therefore, developing self-compassion in nursing students will promote their ability to provide compassionate care.

Linton and Koonmen (2020) discuss self-care as an ethical obligation of nurses. This is based on the American Nurses Association Code of Ethics for Nurses (2015) which states that self-care as much a nurse's duty as caring for others. Watson's (2008) theory supports self-care as an ethical obligation stating that nurses must care for themselves before they can authentically care for others. Linton and Koonmen (2020) support this statement asserting that a lack of self-care in nursing often results in burnout, compassion fatigue, PTSD, moral distress, and even suicide. These issues are so prevalent that self-care can currently be found in several global codes of ethics for nursing (Linton & Koonmen, 2020).

In this study, the theory of human caring (Watson, 2008) provides an explanation of the role of self-compassion in providing compassionate care. According to Watson (2008), self-compassion is intentional loving-kindness toward the self and being mindful of one's inner state of spiritual balance. When practiced as a way of being it enhances the ability to recognize one's interconnectedness with others. Moreover, expanding one's

ways of knowing, being, and becoming that can be applied when providing compassionate nursing practice. Watson (2008) considers caring as a sustainable, conscious connection that deepens shared humanity. Furthermore, stating that a nurse must attend to and care for the self in order be "personally prepared" (Watson, 2008, p. 47) to carry out sustainable compassionate caring practice.

Summary

The body of literature reviewed consists of multiple research methods. Many of these studies utilize Watson's (2008) theory of human caring as a theoretical framework. Therefore, using this theoretical framework with a mixed-method approach to provide a deeper understanding of the perceptions of practicing self-compassion and its role in readiness for professional practice among nursing students; the relationship between nursing students' self-compassion and perceived readiness to practice, and the extent of which students' perceptions of self-compassion confirm outcome data on a readiness to practice measure is supported by the literature.

To date, studies have explored self-compassion in nursing students as it relates to psychological stressors and health, compassionate care, and development methods (Curtis, 2014; Fong & Loi, 2016; Kelly & Tyson, 2016; Luo et al., 2019; Mathad & Pradham, 2017; Neff, 2003b; Neff et al., 2007; Shin & Lim, 2019). Further studies have examined the effects of capstone assignments, perceptions of skills competence, confidence, and imposterism on nursing students' perceptions of readiness for professional practice (Casey et al., 2011; Christensen et al., 2016; Guner, 2014; Usher et al., 2015). However, a gap in the literature exists related to self-compassion as a predictor of positive psychological health in nursing students and its impact on perceptions of

readiness for professional practice. Currently, no known studies have examined the relationship of self-compassion and perceived readiness for professional practice in nursing students. Exploring this topic in nursing students will add to the body of literature exploring the concept of practice readiness and has the potential to provide insight to nursing educators as to areas of psychological support needed by nursing students as they prepare for the transition to professional practice. In Chapter III the research design, setting and sample, procedure, instruments, and data analysis utilized in this study will be explored.

CHAPTER III - METHOD

Introduction

This chapter will discuss the design, setting and sample, procedures, instruments, and data analysis used in this study. A convergent mixed-methods design was used to answer the research questions of this study:

1. What are the perceptions of practicing self-compassion and its role in readiness for professional practice among nursing students?
2. What is the relationship between nursing students' self-compassion and perceived readiness to practice?
3. To what extent do students' perceptions of self-compassion confirm outcome data on a readiness to practice measure?

A quantitative correlational design was used to explore the relationship between self-compassion and readiness for practice in senior nursing students and a qualitative descriptive design was used to expand understanding of that relationship. Quantitative data was collected using online survey software. Qualitative data was collected using interviews and Zoom technology.

Research Design

Mixed-Method Design

The mixed-method approach involves collecting and integrating both qualitative and quantitative data using a design based on philosophical assumptions or a theoretical framework (Creswell & Creswell, 2018). This approach originated in the late 1980s resulting from previous researchers' calls for a more in-depth method to analyze the increasingly complex problems of our time (Creswell & Plano Clark, 2018). The mixed-

method approach assumes that further insight is generated by the integration of the two forms of data rather than either qualitative or quantitative data alone (Creswell & Creswell, 2018). According to Creswell and Plano Clark (2018), the "combination of both forms of data provides the most complete analysis of complex problems" (p. 23). The increasing concern regarding nursing students' psychological health and its impact on future practice is a complex problem. The mixed-method approach provides the holistic perspective needed to thoroughly understand the correlation between self-compassion as a predictor of psychological health and nursing students' perceived readiness for practice and offers further validation of the theory of human caring.

Convergent Design

Convergent designs compare qualitative and quantitative data within the same timeframe; each data set is analyzed separately and then the results are merged or compared (Creswell & Plano Clark, 2018). In addition, convergent designs are used to triangulate the methods by comparing the quantitative statistical results and qualitative findings with the purpose of corroboration and validation (Creswell & Plano Clark, 2018). Using a convergent design will either confirm or disconfirm the results of the two data sets, therefore, validating or negating the hypothesized connection between self-compassion and nursing student perceptions of readiness for professional practice. The convergent design process for this study can be visualized in Figure 2.

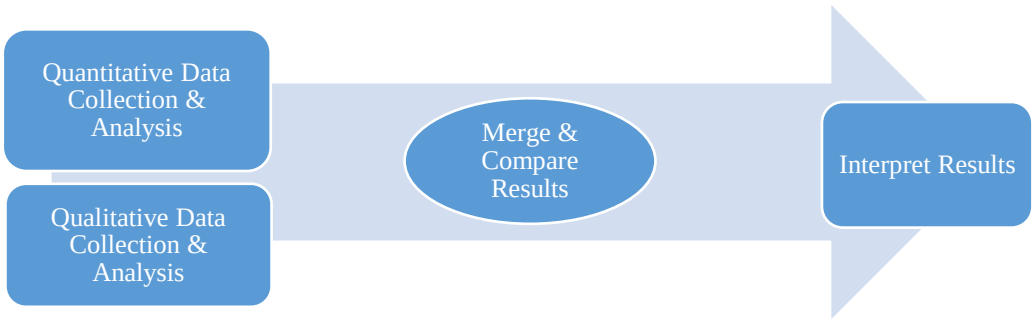

Figure 2. Convergent Mixed-Method Design Process

Note: Quantitative and qualitative data are collected and analyzed separately, and results are merged then interpreted and compared (Creswell & Plano Clark, 2018).

Quantitative Correlational Design. A correlational design was utilized for the quantitative portion of this study. Correlational design is used to identify relationships between variables (Gray et al., 2017). This study sought to identify the relationship between self-compassion and readiness for practice in senior nursing students.

Qualitative Descriptive Design. Qualitative description is used for the qualitative portion of this study. Qualitative description seeks to answer, "the who, what, and where of events" (Sandelowski, 2000, p. 339). It presents a comprehensive, factual description rather than an interpretation (Sandelowski, 2000). This study sought to answer these descriptive questions regarding student perceptions of self-compassion and its role in their readiness for practice.

Setting and Sample

Quantitative Sample

A convenience sample of senior nursing students in baccalaureate programs was invited to participate in this study. Convenience samples are readily accessible and allow for exploration into an unknown area or topic (Gray et al., 2017). Participants were recruited from the Northeastern Region of the United States. The Northeastern Region

includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. Potential bias has been reduced using the specific inclusion criteria; being a senior nursing student enrolled in a baccalaureate program. Pre-nursing, sophomore, junior, associate, and graduate nursing students were excluded. It is important to note that the students sampled in this study have attended nursing school during the COVID-19 pandemic which influenced their perceptions of self-compassion and readiness for professional nursing practice.

Qualitative Sample

Students from the target sample were individually interviewed in consideration of the research questions being explored. All participants were invited to interview until saturation was achieved. Given the depth of inquiry, further described in the procedures section, the target sample to be interviewed was between 12-25 (Gray et al., 2017). The unequal sample sizes support the rigor of each method (Creswell & Creswell, 2018). In qualitative research, a smaller sample is expected as compared to quantitative research. While this may be considered a limitation, this researcher argues that the intent of each method differs; the quantitative data is intended to generalize the population and the qualitative data is intended to provide a deeper understanding (Creswell & Creswell, 2018), therefore, sample sizes suitable for each method are preferred.

Procedures

Internal Review Board (IRB) approval was obtained before beginning recruitment for this study (Protocol #21-263). Students were recruited via email, social networking, and nursing student group pages on Facebook. Nursing Deans or Department Chairs in the Northeastern region of the United States were contacted and requested to forward the

recruitment email to their applicable students. Nursing student group pages on Facebook were contacted for approval to post the recruitment letter on their page. The recruitment email and Facebook post explained the purpose and commitment needed for participation and provided the link to access the consent and survey. Informed consent was reviewed and electronically signed before the start of the survey. The informed consent established an understanding of essential information regarding the study and the agreement of participation (Gray et al., 2017). Because the researcher is employed at one of the universities where students were recruited, it was clearly stated in the recruitment email as well as on the informed consent that participation in this study was completely voluntary and would not impact student coursework in any way. Participation was strictly voluntary. All participants that completed the survey were invited to enter a drawing to win one of two, $25 Amazon gift cards. Participants willing to be interviewed were entered for a chance to win another $25 Amazon gift card. Participants wishing to enter the drawing for gift cards after taking the survey and/or participating in the interviews were asked to enter their email addresses. Contact information was kept confidential, and password protected.

Quantitative Data Collection

The Self-Compassion Scale Short Form (Raes et al., 2011) and the Casey-Fink Readiness for Practice Survey ©2008 (Casey, et al., 2011) were used to examine the relationship between self-compassion and perceptions of readiness for practice. Demographics further describe the sample. Table 1 provides an overview of the variables and corresponding instruments and the number of question items that were utilized in this study.

Table 1

Overview of Variables, Instruments, and Number of Question Items

Variable	**Instrument**	**Independent/Dependent**	**# of Questions or Items**
Readiness for Practice	Casey-Fink Readiness for Practice Survey ©2008	Dependent	20
Self-compassion	Self-Compassion Scale Short Form	Independent	12
Age	Demographics	Independent	1
Gender	Demographics	Independent	1
Race/Ethnicity	Demographics	Independent	1
Employment Status	Demographics	Independent	1
Marital Status	Demographics	Independent	1

Note: One dependent and six independent variables will be used for analysis.

Qualtrics XM software was used for online survey development. Qualtrics is an online survey software with multiple distribution channels making it easy to access for participants (Qualtics, 2022). The survey consisted of 37 questions and was anticipated to take participants approximately 15-30 minutes to complete. To maintain confidentiality the software assigned participant IDs so that the demographics and survey results could be compared. Data collection took place over 30 days. Surveys were collected prior to interviewing.

Qualitative Data Collection

Semi-structured interviews explored the perceptions of self-compassion practices among nursing students and their role in readiness for professional practice. The interviews were conducted via Zoom and were recorded for transcription purposes.

Students were given the option to turn their cameras off if the student wished for comfort and/or anonymity. The interviewing students were provided with a brief definition of self-compassion (see Appendix E) followed by a series of open-ended questions. Probing questions such as “Tell me more”, and “Please provide more detail about…” were used as needed. The interviews questions were:

- How do you practice self-compassion?
- Tell me how your self-compassion practice affects your ability to provide compassionate person-centered care.
- In what ways do you believe your self-compassion practice affects your readiness for professional nursing practice?
- What additional support from your nursing education program would be beneficial in helping you feel psychologically prepared for professional practice?

The interviews were expected to take 20-30 minutes. Memos were taken by the researcher following the interview process. According to Creswell and Poth (2017), memos are concepts, phrases, or ideas that occur to the researcher while reviewing data. In this study, memoing enhanced the researcher’s understanding of the interview transcripts and audio. Memos and transcripts were labeled with an anonymous ID to maintain confidentiality and saved on the researcher’s computer in a password-protected file.

Instruments

The following instruments were used in this quantitative portion of this study: a demographic survey, the Self-Compassion Scale Short-Form, and the Casey-Fink Readiness for Practice Survey ©2008.

Demographic Survey

Demographics are characteristics used to describe the sample (Gray et al., 2017). According to Gray et al. (2017), demographics guide the generalizations, conclusions, and recommendations made by the researcher. In this study, the demographics were considered moderating variables as they may have influenced the major variables, self-compassion, and readiness for practice (Creswell & Creswell, 2018). The common demographic descriptors used in this study mirror those found in much of the literature. The demographics examined were:

1. Age: ≤ 23, 24-30, 31-40, ≥ 41
2. Gender: Male, Female, Non-binary, Other
3. Race/Ethnicity: White/Caucasian, Black/African American, Hispanic/Latino, Asian/Pacific Islander, Native American/ American Indian, Other
4. Employment Status: FT (≥35), PT (<35), unemployed/student
5. Marital Status: Single/never married, married/domestic partnership, widowed, divorced, separated

The age range, gender, and race/ethnicity measured were in consideration of the National League for Nursing (NLN) Biennial Survey of Schools of Nursing 2019-2020 which shows 3.4% of BSN students were over 41 years of age, 13% of BSN students were male, and 30.9% of BSN students were minorities. Based on the NLN (2020)

percentages, these demographics determined if the diversity of the sample was representative of the BSN nursing student population in the United States. In addition, Guner (2014) found that students over the age of 23 generally felt more prepared for practice. Regarding gender, Neff (2003a) found that females reported significantly lower self-compassion than males, and Guner (2014) found that males felt significantly more prepared for practice than females. According to Luo, et al. (2019), nursing students working at least part-time had higher levels of psychological burden which is hypothesized to affect readiness for practice. Finally, Christensen, et al. (2016) found that students with less familial support negatively impacted their feelings of imposterism or self-doubt, implying that marital status/ domestic partnership provides psychological support and positively affects readiness.

Self-Compassion Scale Short Form (SCS-SF)

The SCS-SF was used to measure the levels of self-compassion in senior nursing students (Raes et al., 2011). The SCS-SF is a self-report, five-point Likert Scale survey composed of 12 questions that measure the three components of self-compassion: mindfulness, self-kindness, and common humanity (Raes et al., 2011). These 12 questions were taken from the original 26-item Self-Compassion Scale (Neff, 2003a) with correlation between short and long forms of $r = 0.97$ when measuring the overall concept of self-compassion (Raes et al., 2011). The SCS-SF has proven reliable with a Cronbach's alpha ≥ 0.86 and valid with a confirmatory factor analysis showing an acceptable CFI of 0.97 (Raes et al., 2011). Scores are calculated by first reversing score the negative items 1, 4, 8, 9, 11, and 12, then computing a total mean (Neff, 2021). Scores of 3.51-5.0 equate to high levels of self-compassion, scores of 2.5-3.5 equate to

moderate levels of self-compassion, and scores of 1.0-2.49 equate to low levels of self-compassion (Neff, 2021). The SCS-SF can be viewed in Appendix B.

Casey-Fink Readiness for Practice Survey ©2008

The Casey-Fink Readiness for Practice Survey ©2008 was used to measure the levels of readiness for practice in senior nursing students. It is composed of three sections: the senior practicum experience demographics, skills performance, and a four-point Likert Scale, a self-report survey consisting of 20 items related to comfort/confidence in key practice skills (Casey, et al., 2011). Permission was granted by the authors to solely use the 20-item Likert Scale on comfort/confidence in key practice skills for this research as the senior practicum experience demographics, and skills performance sections were not a focus of this study (see Appendix D). The Casey-Fink Readiness for Practice Survey ©2008 comfort/confidence section has proven to be both reliable and valid with a Cronbach's alpha = 0.69, exploratory factor analysis validating subscales of "clinical problem solving, learning techniques, professional identity and trials and tribulations" (p. 648), and confirmatory factor analysis showing an acceptable CFI of 0.86 (Casey, et al., 2011). This study focused on the overall concept of readiness for practice. Scores were calculated by first reversing score the negative items 4, 5, 8, and 9, then computing the sum. The sum of the scores was taken with the lowest score of 20 and the highest score of 80. The higher the sum of the scores are correlated to higher readiness. The Casey-Fink Readiness for Practice Survey ©2008 can be viewed in Appendix C.

Data Analysis

The quantitative and qualitative data were analyzed separately and then merged and compared for the final interpretation (Creswell & Plano Clark, 2018). The side-by-side comparison sought to use the quantitative and qualitative data sets to confirm or disconfirm results (Creswell & Creswell, 2018) which provided validation and confirmation of the results (Creswell & Plano Clark, 2018). Table 2 presents each research question, its associated variables, and the tools and methods used for analysis.

Table 2

Data Analysis

Research Question	**Variables**	**Analysis**
What are the perceptions of practicing self-compassion and its role in readiness for professional practice among nursing students?	Self-compassion-independent Readiness for Practice-dependent	Interview data Open-ended questions
What is the relationship between nursing students' self-compassion and perceived readiness to practice?	Age-independent Gender-independent Ethnicity-independent Employment Status-independent Marital Status-independent	Demographic Survey
	Self-Compassion-independent	SCS-SF
	Readiness for Practice-dependent	Casey-Fink Readiness for Practice Survey ©2008
To what extent do students' perceptions of self-compassion confirm outcome data on a readiness to practice measure?	Age-independent Gender-independent Ethnicity-independent Employment Status-independent Location-independent Self-Compassion-independent Readiness for Practice-dependent	Integration of mixed methods data and meta inferences

Quantitative Analysis

The quantitative data analysis of this study addressed the question: What is the relationship between nursing students' self-compassion and perceived readiness to practice? Based on the theoretical framework, Watson's theory of human caring (2008), it was hypothesized that self-compassion would positively influence perceived readiness for practice. *IBM SPSS Statistics 28 for Windows*® was utilized to perform the quantitative data analysis. Reliability analyses of the scales was performed using Cronbach's alpha coefficients. Demographics were obtained to better describe the sample. Descriptive statistics, such as mean, standard deviation, and range (Frey, 2016), explain the levels of self-compassion and readiness for practice in undergraduate senior nursing students. Bivariate analysis using Spearman's rho correlation coefficient a was conducted to determine relationships and multivariate analysis using multiple linear regression was conducted to determine the direction and strength of any linear relationships between the dependent variable, perceived readiness for practice, and the independent variables, self-compassion, and the demographics: age, gender, race/ethnicity, employment status and marital status (Frey, 2016). Results were password-protected to maintain confidentiality.

To detect a significant association between self-compassion and nursing student readiness for practice, a power analysis was done to determine the target sample size (Creswell & Creswell, 2018). The targeted power ($1 - \beta$) was 0.8, and the significance level was set to 0.05 ($\alpha = 0.05$). Along with the different effect sizes from small ($\delta = 0.02$), to medium ($\delta = 0.15$), to large ($\delta = 0.35$), the sample sizes were calculated using G-Power ver. 3.1.9. Based on the results, a total of 55 responses would be adequate if

medium effect size is assumed. In consideration of (1) missing values or (2) incomplete surveys as 20 to 30 % of the respondents, the target sample was 85 to 90 senior nursing students.

Qualitative Analysis

Directed content analysis was used to analyze the qualitative data (Hsieh & Shannon, 2005). Qualitative content analysis uses pre-existing or data-derived codes that can be modified to accommodate new insights (Sandelowski, 2000). Interview transcripts and memos were entered into the Quirkos 2.4.2 software program. Quirkos is qualitative research software that assists in the coding process by easing the managing and sorting of word-based data to pull out common themes and generate visual representations (Quirkos, 2022).

Trustworthiness is an alternative term for validation that Lincoln and Guba (1985) assert to be a more appropriate term for qualitative research. To establish trustworthiness the researcher must demonstrate credibility, transferability, dependability, confirmability, and authenticity (Creswell & Poth, 2017; Lincoln & Guba, 1985). Validity strategies such as triangulation, presentation of negative or discrepant information, thick description, and peer review were used to establish trustworthiness (Creswell & Creswell, 2018; Creswell & Poth, 2017; Lincoln & Guba, 1985). Using triangulation methods, different sources are used to corroborate data. For this study, interview transcripts, interview audio, and the Theory of Human Caring were used to corroborate the findings (Creswell & Poth, 2017; Lincoln & Guba, 1985). Presenting negative or discrepant information reveals any data that does not fit into the determined codes and themes and highlights them as important points deserving of further discussion (Creswell & Poth, 2017). A thick description

provides a detailed account of the participant characteristics and study activities (Creswell & Poth, 2017; Lincoln & Guba, 1985). Finally, transcripts and audio were reviewed multiple times to ensure the accuracy of data, and the findings were summarized. A sample of five transcripts and summaries were then be reviewed by another reader to confirm the findings.

Mixed-Methods Analysis

Results from the interviews were integrated with the quantitative statistics in a side-by-side comparison. A side-by-side comparison identifies and describes direct connections that either provide support or oppose the theoretical framework of the study (Creswell & Creswell, 2018). Inferences and meta-inferences were drawn from and across the data (Creswell & Plano Clark, 2018). The comparison integration lends to potential divergence which would warrant further exploration into the data sets in search of resolution (Creswell & Creswell, 2018). Interpretation involved working to understand how these discrepancies provide further insight into understanding the relationship between self-compassion and readiness for practice (Creswell & Plano Clark, 2018).

Summary

A convergent mixed methods design utilizing an online survey and semi-structured interviews is used in this study. The purpose of this study is to explore the relationship between self-compassion and perceived readiness for practice among nursing students. A convenience sample of undergraduate senior nursing students enrolled in baccalaureate programs will be used for this study. Quantitative data will be collected via Qualtrics XM and analyzed with IBM SPSS Statistics 26 for Windows®. Qualitative data will be collected via interview and analyzed with Quirkos 2.4.2 software. Both data sets

will then be merged and compared for interpretation. Going forward in Chapter IV, the presentation and analysis of the data will be discussed.

CHAPTER IV – RESULTS

Introduction

This chapter presents the quantitative and qualitative results of this study. A review of the quantitative survey tools used, and data analysis will be discussed followed by the qualitative interview data analysis. In addition, the side-by-side comparison of both data sets will be described, and an explanation of the findings will be discussed.

Quantitative Results

The quantitative data in this study depicts the relationship between nursing students' self-compassion and readiness to professional nursing practice. Additionally, demographics were examined as potential influencers of readiness for practice. The quantitative data reflects the survey responses of 82 participants. Survey data was downloaded from Qualtrics XM into SPSS version 28 for analysis. Descriptive statistical analysis, bivariate analysis, and multivariate multiple linear regression were conducted.

Demographic Survey

Most participants in this study were ≤ 23 years old (n=68, 82.9%) while 17.1% of participants were > 23 years old (n=14). Participant gender was predominantly female (n=75, 91.5%); all others identified as male (n=7, 8.5%). Over half of the participants were employed (n=52, 63.4%) and 36.6% of participants were students/unemployed (n=30). The age, gender, and employment status variables were collapsed to increase the sample size within the groups of each variable to obtain meaningful information. Regarding race/ethnicity, 73.2% of participants identified as White/Caucasian (n=60), 11% as Asian/Pacific Islander (n=9), 9.8% as Hispanic/Latino (n=8), 3.7% as Black/African American (n=3), and 2.4% identified as Other (n=2). No participants

identified as Native American/American Indian. Regarding marital status, 92.7% were single/never married (n=76), 4.9% were married/domestic partnership (n=4) and 2.9% were divorced (n=2). No participants reported being separated or widowed. Race/ethnicity and marital status were not collapsed. See Table 5 for a complete representation of the data.

Bivariate analysis was conducted to determine the relationships between readiness for practice and the demographic variables. Results determined that there was a relationship between readiness for practice and marital status as the p-value is less than the significance level of 0.05. There were no significant relationships between readiness for practice and age, gender, race/ethnicity, or employment status. See Table 6 for a visual of the bivariate analysis between perceived readiness and the independent variables using Spearman's rho. Using multiple linear regression, a multivariate analysis was conducted to determine the direction and strength of any linear relationships between readiness for practice and the demographics variables. Results revealed a linear relationship between readiness for practice and marital status. See Table 7 for the multiple linear regression statistics model summary.

Self-Compassion Scale Short Form (SCS-SF)

Participants completed the SCS-SF which measured levels of self-compassion. The following 12 questions were answered using the Likert scale: 1-Almost never; 2-Somewhat never; 3- Neutral; 4- Somewhat always; 5- Almost always. See Appendix B for complete SCS-SF.

Table 3

Self-Compassion Scale Short Form Questions

SCS-SF Questions
1. When I fail at something important to me, I become consumed by feelings of inadequacy.
2. I try to be understanding and patient towards those aspects of my personality I don't like.
3. When something painful happens I try to take a balanced view of the situation.
4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
5. I try to see my failings as part of the human condition.
6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
7. When something upsets me, I try to keep my emotions in balance.
8. When I fail at something that's important to me, I tend to feel alone in my failure
9. When I'm feeling down, I tend to obsess and fixate on everything that's wrong.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm disapproving and judgmental about my flaws and inadequacies.
12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Scores were calculated by reversing the negative items and then computing the total mean. High levels of self-compassion equate to 3.51-5.0, moderate levels of self-compassion equate to scores of 2.5-3.5, and low levels of self-compassion equate to scores of 1.0-2.49 (Neff, 2021). Descriptive statistical analysis determined 58.5% of participants have a moderate level of self-compassion (n=48). The remaining participants were evenly split between high and low scores with 20.7% (n=17) each. Bivariate analysis was conducted using Spearman's rho to determine the relationship between readiness for practice and self-compassion. Results determined that there is a significant relationship between readiness for practice and self-compassion as the p-value is less than the significance level of 0.05. See Table 6, for a visual of the bivariate analysis between perceived readiness and the independent variables.

For the multivariate analysis, multiple linear regression was used to determine that a linear relationship exists between readiness for practice and self-compassion. See

Table 7 for model statistics. Cronbach's alpha was conducted to confirm scale reliability. According to Creswell and Creswell (2018), Cronbach's alpha scores of 0.7-0.9 are optimal. In the study's sample, the Cronbach's alpha determined a score of 0.846, thus confirming the SCS-SF to be reliable.

Casey-Fink Readiness for Practice Survey ©2008

Participants completed the Casey-Fink Readiness for Practice Survey ©2008 which measured levels of perceived readiness for professional nursing practice. The survey consists of three sections: 1) demographics related to the senior practicum experience, 2) a 20 item Likert scale related to comfort/confidence in clinical and relational skills, and 3) two opened-ended questions related to career choice and further preparation, however, with the authors' permission, only the 20 items Likert scale section of the tool was used in this study. This Likert section of the tool focuses on the level of comfort/confidence in performing key nursing activities identified as the four domains of readiness: clinical problem solving, learning techniques, professional identity, and trials and tribulations (Casey, et al., 2011). The following 20 questions, as listed in Table 4, were answered using the Likert scale: 1-Strongly disagree; 2-Somewhat disagree; 3-Somewhat agree; 4-Strongly agree. See Appendix C for the complete Casey-Fink Readiness for Practice Survey ©2008.

Table 4

Casey-Fink Readiness for Practice Survey ©2008

1. I feel confident communicating with physicians.
2. I am comfortable communicating with patients from diverse populations.
3. I am comfortable delegating tasks to the nursing assistant.
4. I have difficulty documenting care in the electronic medical record.
5. I have difficulty prioritizing patient care needs.

Table 4 (continued).

6. My clinical instructor provided feedback about my readiness to assume an RN role.
7. I am confident in my ability to problem-solve.
8. I feel overwhelmed by ethical issues in my patient care responsibilities.
9. I have difficulty recognizing a significant change in my patient's condition.
10. I have had opportunities to practice skills and procedures more than once.
11. I am comfortable asking for help.
12. I use current evidence to make clinical decisions.
13. I am comfortable communicating and coordinating care with interdisciplinary team members.
14. Simulations have helped me feel prepared for clinical practice.
15. Writing reflective journals/logs provided insights into my own clinical decision-making skills.
16. I feel comfortable knowing what to do for a dying patient.
17. I am comfortable taking action to solve problems.
18. I feel confident identifying actual or potential safety risks to my patients.
19. I am satisfied with choosing nursing as a career.
20. I feel ready for the professional nursing role

Scores were calculated by reversing the negative items and then taking the sum of the scores. Scores range from 20, indicating a low perception of readiness, to 80, indicating a high perception of readiness. The higher the score, the higher level of readiness for practice. Descriptive statistical analysis established that participant scores ranged from 41 to 75 with a mean score of 60.34 indicating participants had overall moderately high perceptions of readiness for practice. The range of readiness for practice score distribution can be visualized in Figure 3. Cronbach's alpha was conducted and determined a score of 0.842, which confirm the Casey-Fink Readiness for Practice Survey ©2008 to be reliable.

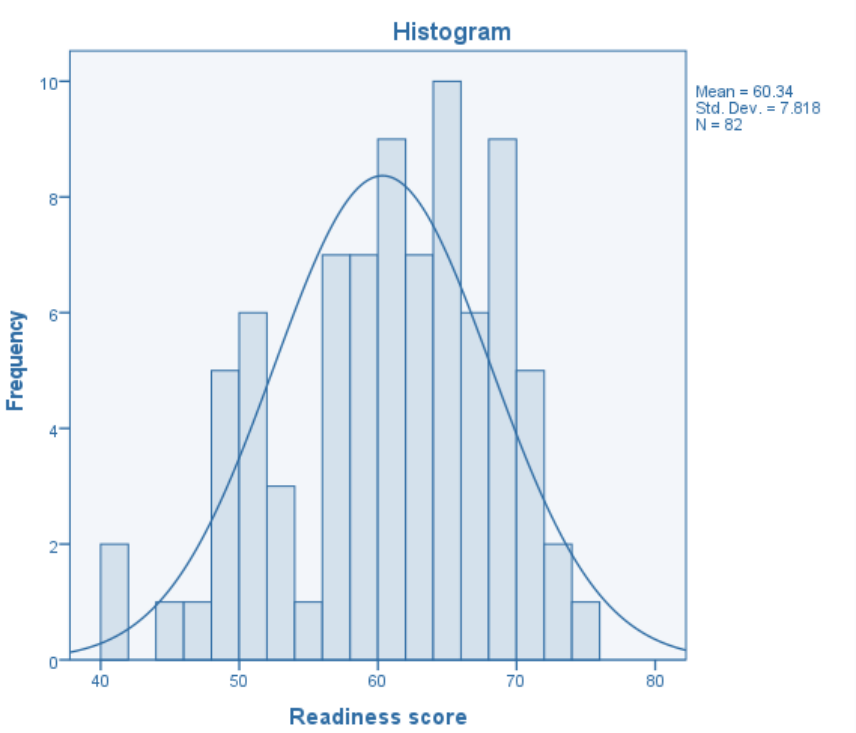

Figure 3. Readiness for Practice Histogram with a Normal Curve

Note: Histogram from IBM SPSS Statistics 28 for Windows®

As previously noted, bivariate analysis was conducted to determine relationships between readiness for practice and the independent variables age, gender, race/ethnicity, employment status, marital status, and self-compassion. Results determined that self-compassion and marital status have a significant relationship with readiness for practice as the p-value is less than the significance level of 0.05. See Table 6 for a visual of the bivariate analysis between perceived readiness and the independent variables.

For the multivariate analysis, an ANOVA overall F-test was used to conduct the multiple linear regression analysis which tested the hypothesis that at least one linear regression exists between the dependent and independent variables. See Table 7 for ANOVA statistics. The F-test statistic ($p<0.001$, $df=2$) revealed that at least one linear relationship between the outcome variable and any independent variable exists. The VIF

showed that there are no independent variables with a multicollinearity effect (VIF <2.00). Backward elimination of the independent variables revealed self-compassion and marital status as final predictors. The individual t-tests showed that self-compassion is a statistically significant predictor (t=2.959, p=0.004) and that marital status approached statistical significance (t=1.895, p=0.062) for perceived readiness. Models 1-4 showed marital status as significant (p=0.033-0.037) yet the removal of gender from model 4 negatively affected the significance of marital status in the final model (5). Therefore, marital status may still be considered a meaningful predictor and should not be discarded without further exploration into the marital status and/or gender to gain an understanding of this inconsistency. See Table 8 for Individual t-test statistics. The final linear regression model is $\hat{y} = \beta_0 + \beta_1 x_1 + \beta_2 x_2$ or more specifically, $\hat{y}$(readiness) = 49.438 + 3.735(Self-compassion) + 3.060(Marital Status).

Table 5

Descriptive Statistics of Demographic and Study Variables

Variable	N	%	Mean (SD)
Age			
≤23	68	82.9	
>23	14	17.1	
Gender			
Male	7	8.5	
Female	75	91.5	
Other	0	0	
Race/Ethnicity			
White/Caucasian	60	73.2	
Black/African American	3	3.7	
Hispanic/Latino	8	9.8	
Asian/Pacific Islander	9	11.0	
Native American/American Indian	0	0	
Other	2	2.4	

Table 5 (continued).

Employment Status			
Employed	52	63.4	
Student/Unemployed	30	36.6	
Marital Status			
Single/ Never married	76	92.7	
Married/Domestic Partnership	4	4.9	
Widowed	0	0	
Divorced	2	2.4	
Separated	0	0	
Self-Compassion			
Low	17	20.7	
Moderate	48	58.5	
High	17	20.7	
Readiness for Practice	82		60.34 (7.818)

Table 6

Bivariate Analysis between Perceived Readiness and Independent Variables using Spearman's rho

Variable	**Independent Variable**	**Test**	**Test Statistic**	**P**
Readiness	Self-Compassion	ρ	.299	<0.001
	Age	ρ	-.024	.831
	Gender	ρ	.079	.478
	Race/Ethnicity	ρ	-.096	.391
	Employment Status	ρ	.017	.882
	Marital Status	ρ	.218	.049

Table 7

ANOVA (Overall F-test)

Model	**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Regression	668.945	2	334.472	6.172	.003
Residual	4281.494	79	54.196		
Total	4950.439	81			

Table 8

Individual T-test Statistics

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearly Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	46.094	8.324		5.538	.000		
	Self-Compassion	3.483	1.294	.289	2.691	.009	.966	1.036
	Age	-1.589	2.013	-.100	-.790	.432	.697	1.435
	Gender	2.802	3.145	.101	.891	.376	.868	1.152
	Race/Ethnicity	-.696	.657	-.112	-1.060	.292	.998	1.002
	Employment Status	.104	1.529	.008	.068	.946	.914	1.094
	Marital Status	4.247	1.951	.275	2.176	.033	.695	1.439
2	(Constant)	46.306	7.677		6.032	.000		
	Self-Compassion	3.487	1.285	.289	2.712	.008	.967	1.034
	Age	-1.581	1.996	-.099	-.792	.431	.700	1.429
	Gender	2.827	3.104	.102	.911	.365	.880	1.136
	Race/Ethnicity	-.696	.652	-.112	-1.066	.290	.999	1.001
	Marital Status	4.215	1.885	.273	2.236	.028	.735	1.360
3	(Constant)	43.809	6.983		6.274	.000		
	Self-Compassion	3.657	1.264	.303	2.894	.005	.995	1.005
	Gender	3.343	3.027	.120	1.104	.273	.921	1,086
	Race/Ethnicity	-.685	.651	-.110	-1.052	.296	.999	1.001
	Marital Status	3.539	1.676	.229	2.111	.038	.925	1.081
4	(Constant)	42.814	6.923		6.184	.000		
	Self-Compassion	3.639	1.264	.301	2.878	.005	.995	1.005
	Gender	3.270	3.028	.118	1.080	.284	.921	1.086
	Marital Status	3.555	1.677	.230	2.120	.037	.925	.081
5	(Constant)	49.438	3.212		15.389	.000		
	Self-Compassion	3.735	1.263	.310	2.959	.004	1.000	1.000
	Marital Status	3.060	1.615	.198	1.895	.062	1.000	1.000

Quantitative Results Summary

Data analysis determined and examined the relationships between the dependent variable, readiness for practice, and the following independent variables: age, gender, race/ethnicity, employment status, marital status, and self-compassion. Descriptive statistical analysis presented demographical information of the sample, levels of self-compassion, and levels of readiness for practice. The bivariate analysis found significant correlational relationships between the dependent variable, readiness for practice, and two of the independent variables: self-compassion and marital status. Multivariate multiple linear regression found linear relationships between the dependent variable, readiness for practice, and the independent variables: self-compassion and marital status. The final model did not show marital status as significant ($p>0.05$) however, without further exploration it should not be discarded given its significance in the preceding models ($p<0.05$). According to Gray et al. (2017), this inconsistency may be a result of the sampling method and size given that convenience sampling can lend to a problematic representation of a target population. The hypothesis that self-compassion positively influences perceived readiness for practice in nursing students was supported by the data ($p<0.001$).

Qualitative Analysis

The qualitative data in this study depicts student perceptions of the relationship between self-compassion and readiness for professional nursing practice. Eighteen students participated in the interviews. Interviews were recorded, downloaded, and transcribed. Coding and direct content analysis followed. The coding and analysis process will be described, and the results will be presented.

Interviews were conducted via Zoom and averaged 10:37 minutes in length. A reflective journal was kept immediately following each interview that consisted of memos summarizing key points made by the participant and reflections of the researcher. The interview audio was downloaded, and the audio and journal were saved in a password-protected file for transcription and further review. The interviews were transcribed, and the audio was reviewed while reading the transcripts multiple times to ensure the accuracy of the data. Transcripts were then uploaded into the Quirkos 2.4.2 software program for coding and analysis. Each interview transcript was coded by grouping and labeling units of data based on identified perceptions. Twenty-five initial codes were identified from the data (see Figure 4) and then categorized into broader concepts which revealed six themes. Four of the themes directly correlate to one of the interview questions. Theme 1 relates to question 1, theme 2 relates to question2, theme 3 relates to question 3, and theme 4 relates to question 4. The remaining two themes were correlated to more than one question. Theme 5 relates to questions 1 and 4, and theme 6 relates to questions 1, 3, and 4. Each theme and interview question will be further discussed. See Table 9 for a visual of themes and subthemes.

Figure 4. Initial Qualitative Codes Sized Based on Number of Data Units

Theme 1: Practicing Self-Compassion

Theme 1 relates to the first interview question: *How do you practice self-compassion?* This question sought to understand if and how nursing students practice self-compassion. Under Theme 1, three subthemes were identified: perceptions, challenges, and practices of self-compassion. Each subtheme will be discussed.

Perceptions. The general perception of participants was that practicing self-compassion can be difficult to practice yet beneficial and that over time, one can develop their practice which will enhance their resiliency. One participant stated, "It's difficult" and, "I think everyone could use a little practice in it and make it more of a focus because (…) I think we neglect ourselves." Other participants said, "It's very beneficial (…) it centers me" and "Self-compassion for me [is] accepting that I'm not going to be perfect." Regarding development and resiliency, participants stated, "I feel like self-compassion is something that if you don't have it right at the beginning you could develop it pretty easily" and "[In nursing] I think you have to have some kind of resiliency plan (…) and

having the tools to admit when you're wrong and how to care for yourself if you make a mistake (…) is really essential."

Challenges. Several participants perceived practicing self-compassion as challenging, citing stressors related to nursing school. For example, one participant stated, "In my own personal struggles, I think I could use some work [however] I think nursing school is difficult, so there's not a lot of time." Another participant stated, "As a student, a nursing student especially, class is not always [the] easiest thing. I think in terms of grades and stuff, self-compassion is something that I'm still working on." Other participants commented on self-compassion challenges in the clinical setting such as: "In the clinical setting (…) if I do mess up with something, I tend to hold it in and be extra cautious in the future", and "It's a hard line between balancing having compassion for myself and knowing that (…) if I make a mistake, it's not just a mistake. It could [hurt] someone". Participants also noted that having compassion for others is sometimes easier than having compassion for themselves. "I think I could honestly use what I do for my patients for myself better" and, "I think everyone could use a little practice in [self-compassion] and make it more of a focus because what we do is helping people, which is amazing (…) but at the same time, I think we neglect ourselves".

Practices of Self-Compassion. The practice of self-compassion centered around self-care, personal reflection, and Neff's (2003b) components of self-compassion: self-kindness, common humanity, and mindfulness. Several participants focused on self-care as a means to increasing and/or practicing self-compassion. One participant stated, "I like to always set aside time for myself because I almost see it [self-compassion] as the same thing as self-care (…) self-care is still being compassionate to yourself." and "I feel it's

really important to have self-care practices when you are really emotionally burnt out." Another stated, "I definitely incorporate it [self-compassion] in self-care (…) just doing things that make me feel good or make me feel my best." Journaling, reading, working out, adequate sleep, and yoga were among the self-care techniques mentioned that participants felt aided in their practice of self-compassion. A personal reflection was perceived as an important element of practicing the components of self-compassion. One participant stated, "I practice self-compassion just by taking time to reflect at the end of the day." Another participant stated, "I've been trying to be more aware of when I'm trying to get more tasks done [and] how that's impacting my mental health and my self-care and everything." Regarding the components of self-compassion, one participant stated, "it's taking time to be like, 'Okay, that went wrong. How do I fix it? (...) It's okay, I'm not a bad person. I just messed up." Another stated, "the number one thing I do (…) [is] basically allow myself to feel anything. If it's negative, I'll give myself time, just let myself feel it, and I think about why."

Theme 2: Reciprocal Relationships of Compassionate Care

Theme 2 relates to the second interview question: *Tell me how your self-compassion practice affects your ability to provide compassionate person-centered care*. This question was used to understand student perceptions of the relationship between self-compassion and compassionate care. Most participants felt that self-compassion and compassionate care have a reciprocal relationship. One participant stated, "If I'm compassionate to myself, I'll be able to give the care that the patients need and deserve." Another participant stated, "It [self-compassion] centers me so that way when I go in there, I'm all about the patient." It's important to note that one participant did not

perceive a reciprocal relationship, stating “I don’t think my self-compassion affects other people because (…) I can help them get through it easier than I can help myself get through.”

Theme 3: Components of Readiness

Theme 3 relates to the third interview question: *In what ways do you believe your self-compassion practice affects your readiness for professional nursing practice?* This question sought to understand student perceptions of the role if any, that self-compassion plays in their perceptions of readiness to take on the role of the professional nurse. Overall, participants felt ready to enter professional nursing practice citing foundational practices such as knowledge, skills, and self-care as having an impact on their readiness. For example, one participant stated, “I feel that what I’ve gone through, with school and also my current job, [has helped me] feel prepared to go into the nursing role in the future.” Self-compassion was seen as a positive influence of readiness for practice. One participant stated, “I definitely could use more self-compassion practice in order to be ready for nursing because being in clinicals reminds me that sometimes my own emotions get the best of me.” Another said, “I know that the first year of nursing, after graduation, is going to be a big learning curve and I feel like if I can work on my self-compassion skills, then I’ll be ready and more open to learning.” Finally, one stated, “I think because I am able to let things go and just learn from them, that that helps me to be more ready, than if I were to hold onto them.” It is important to note that one participant did not perceive that self-compassion influenced readiness for practice stating that “I think it’s something that we’ll all get at some point, (…) I don’t think it puts me [at] an advantage at all or particularly ready.”

Theme 4: Education/Training Needs

Theme 4 relates to the fourth interview question: *What additional support from your nursing education program would be beneficial in helping you feel psychologically prepared for professional practice?* This question was used to gain an understanding of what types of additional support students perceived as helpful to better prepare them for the psychological element of nursing practice. There were 3 subthemes: Supportive approaches, experience with difficult situations, and self-compassion/self-care training. Each subtheme will be discussed.

Supportive Approaches. Although some participants felt their programs were very supportive 'as is', other participants suggested more supportive approaches to nursing school expectations. For example, one participant suggested that clinical debriefings focus on "these are the things you did well, these are the things you can work on, and here's how you can work on them, and then maybe a check-in the next time to see how that advice is going." Another participant suggested being more supportive in general stating, "we're told to practice self-care [and] we're told to love our patients but how can we do that when (…) it's all or nothing? You have to be 100% all the time or you're not going to cut it."

Experience with Difficult Situations. Regarding more experience with difficult situations, one participant stated, "at least in my experience, when something gets disruptive or a patient gets means, they remove us from the situation, which I understand, but at the same time, how are we going to learn how to deal with it?" Another participant stated, "I would like to be more prepared on (…) dealing with people who are

argumentative." Students also suggested more simulations, interactive scenarios, and case studies on this topic.

Self-Compassion/Self-Care Training. Several participants mentioned a need for self-care and/or self-compassion training. For example, one participant suggested creating a dedicated course.

> I almost feel like they should make a 1 credit self-care or mindfulness course (…). Everyone talked about [self-care] in so many classes, (…) but it was like a 10-minute discussion in one lecture in the beginning of the class (…) and I almost wish someone forced me to have a class where I could focus on that for myself (…). That's the one thing I think almost should be universal in a way.

Other participants suggested weaving self-compassion and self-care training into the curriculum. For example, one stated, "incorporating into a lecture or into the clinical rotations just ways to practice self-compassion, ways to de-stress, ways to deal with burnout and everything like that." Another stated:

> I remember when I was a freshman, they told us they care about our mental health, but I think that it was very empty because since then, I know for myself and for others, we haven't really practiced self-compassion and just self-care to the extent that I think that the nursing school would want us to because the curriculum is hard, and I understand that. (…) having more of a focus on self-compassion in nursing schools, I think, would be very helpful because I know that burnout and that kind of thing are really prevalent in the nursing field so I feel like if we were to learn more or about that in college it would go a long way.

Theme 5: Other Themes-Influence of Support Systems

Theme 5 relates to 2 of the 4 interview questions. Support systems, including family, friends, and faculty/resources, were perceived as aiding with practicing self-compassion, and beneficial for psychological preparedness. Regarding practicing self-compassion, one participant stated, "If I feel like I've had a hard day at work or in school and I feel stressed out, I remind myself that I'm not alone by talking to my friends about how they're feeling and we just kind of bounce off each other." Regarding psychological preparedness, participants cited knowing your resources and the need for faculty/resource support as important. For example, one participant stated, "Just know that there are resources out there and you can make it". Another stated,

> When I first started nursing school, we had one day where the Counseling Center came in and did some breathing exercises or relaxation techniques with us. I think that is something that should be kept up all four years of nursing school because the stress just adds on as we go and sometimes having a little mental check helps.

Another stated, "maybe having a group, or something, just for students to share their feelings (…) saying, 'This is how I feel' or, 'I have anxieties over' say, over COVID, or something like that, (…). Just trying to put it more out there, so we all become comfortable."

Theme 6: Other Themes-Influence of the COVID-19 Pandemic

Theme 6 relates to 3 of the 4 interview questions. This theme has two subthemes: positive influence, and negative influence. Participants were both positively and negatively influenced by the COVID-19 pandemic regarding choosing the nursing profession. For example, one participant stated,

> I started working as a tech (…) in March 2020 (…) which was the week that everything shut down (…). When I started on the floor it was right in the thick of COVID and it was confusing. I'm literally learning, I'm getting pushed into the fire, and everything and for the briefest second, I swear I was like (…) 'Do I want to continue doing this?' and actually I think (…) my feelings for wanting to be a nurse are stronger than ever.

While another participant stated, "I have to remember why I started because over the past year I'm [thinking] 'do I really want to do this?' and (…)' I hope this is going to be the right choice for me.'" And another participant stated, "It feels difficult to go into nursing right now because of the COVID situation and I feel [that] people don't care about healthcare workers [like] at the beginning."

Positive Influence. The participants positively influenced by the COVID-19 pandemic expressed enhanced self-compassion and self-care practices. For example, one participant stated, "I think, since COVID especially, I've really tried to be more attentive to my own needs." Another participant stated that, "COVID really impacted how I practice self-care and self-compassion" and "just having time to actually slow down and realize how meaningful and how much I actually want to do it (…) keeps you present and mindful".

Negative Influence. The participants negatively influenced by the COVID-19 pandemic expressed a lack of hands-on experience and concern over readiness and potential burnout. Regarding the lack of experience, one participant stated, "I know it was very hard because of COVID, but I just feel like we could have [had] more hands-on experience." Another participant stated, "I like that we do (…) simulation labs and all

that, but in a way, I feel like we didn't exactly get as much [experience] as we could have." Another participant expressed fears of readiness regarding patient families stating,

> I've had a lot of patient encounters, but not a lot of encounters [with] patients' families because of COVID (…). I feel that has really affected how prepared I am to go into nursing (…) when visitors are allowed back."

Regarding potential burnout, one participant stated, "Now that it's senior year, and we've gone through almost two years now of a pandemic, you really start seeing, 'Wow, all these nurses are leaving and it's because they're tired, they're burned out." Another participant stated, "I know from my friends who have gone into nursing already over the past couple of years, that's it's obviously been really difficult" and "it's been an emotional struggle for a lot of people."

Table 9

Themes and Subthemes

Theme	**Subtheme**
Practicing Self-Compassion	Perceptions of Self-Compassion Challenges to Self-Compassion Ways to Practice Self-Compassion
Reciprocal Relationships of Compassionate Care Components of Readiness	Foundational Practices Self-Compassion Influence
Education/Training Needs	Support Approaches Experience with Difficult Situations Self-compassion/Self-care Training
Influence of Support Systems	
Influence of the Covid-19 Pandemic	Positive effects Negative effects

Qualitative Results Summary

Data analysis examined the perceptions of practicing self-compassion and its role in readiness for professional practice among 18 nursing students. Twenty-five codes were identified (see Figure 4) and six themes emerged:

1. Practicing self-compassion
2. Reciprocal relationships in compassionate care
3. Components of Readiness
4. Education/training needs
5. Influence of support systems
6. Influence of the COVID-19 Pandemic.

Trustworthiness was established using triangulation, presentation of negative or discrepant information, thick description, and peer review as suggested by Creswell and Creswell (2018). Triangulation was conducted by corroborating the interview audio, transcripts, and Watson's theory of human caring (2008). Negative or discrepant information was provided with relevant theme findings. A thick description of the qualitative data analysis process was described. The participants were described in detail and quotes were used to provide context to each theme (Creswell & Poth, 2017). Finally, a doctorally prepared nurse reviewed five transcripts, and correlating memos and summaries to confirm the categories.

Mixed-Methods Analysis

The quantitative and qualitative data were integrated, and a side-by-side comparison was conducted. Data integration is used to confirm, disconfirm, or expand understanding of each data set (Creswell & Plano Clark, 2018). The integrated

comparison determined that students' perceptions of self-compassion and readiness for practice confirmed the outcome data on the readiness to practice measure within the theoretical framework of this study. The three following meta-inferences were determined:

1. Support systems, such as marital status, positively influence self-compassion and readiness for practice.
2. Self-compassion increases one's ability to provide compassionate care, therefore, increasing one's readiness to practice.
3. The COVID-19 pandemic has influenced levels of self-compassion and readiness for the practice among nursing students.

Table 10

Mixed-Methods Integration

Quantitative Results	**Qualitative Results**	**Mixed-Methods Comparison**
Marital status positively influences readiness for practice Self-Compassion positively influences readiness for practice	Practicing Self-Compassion Reciprocal Relationships of Compassionate Care Components of Readiness Wellness Education/Training Needs Influence of Support Systems Influence of the COVID-19 Pandemic	Support systems, such as marital status, positively influence self-compassion and readiness for practice. Self-compassion increases one's ability to provide compassionate care therefore positively influencing one's perceptions of readiness to practice. The COVID-19 pandemic has influenced levels of self-compassion and readiness for the practice among nursing students.

Summary

Chapter IV presented the quantitative and qualitative data analysis, mixed methods integration, and the findings of each method. Instrument reliability was also included. In Chapter V, a discussion of the findings, limitations of the study, recommendations for future research, and the conclusion of the study will be presented.

CHAPTER V – CONCLUSION

Chapter V will discuss the findings from the quantitative, qualitative, and mixed-method analyses. Each research question and its applicable findings will be explored, including any discrepancies. Limitations of the study and recommendations for future research will also be discussed.

Discussion

This study utilized a convergent, mixed-methods design to corroborate findings from the quantitative and qualitative analyses regarding the relationship between self-compassion and perceived readiness for practice in nursing students. According to Creswell & Plano Clark (2018), a mixed-methods design was used to explore a deeper understanding of the research problem. In this study, the mixed-methods design established a relationship between self-compassion and perceived readiness for practice and provided a context and perception of that relationship. Figure 5 illustrates the mixed-methods procedural design used in this study to provide an understanding of the flow of data collection, analysis, and interpretation (Creswell & Plano Clark, 2018).

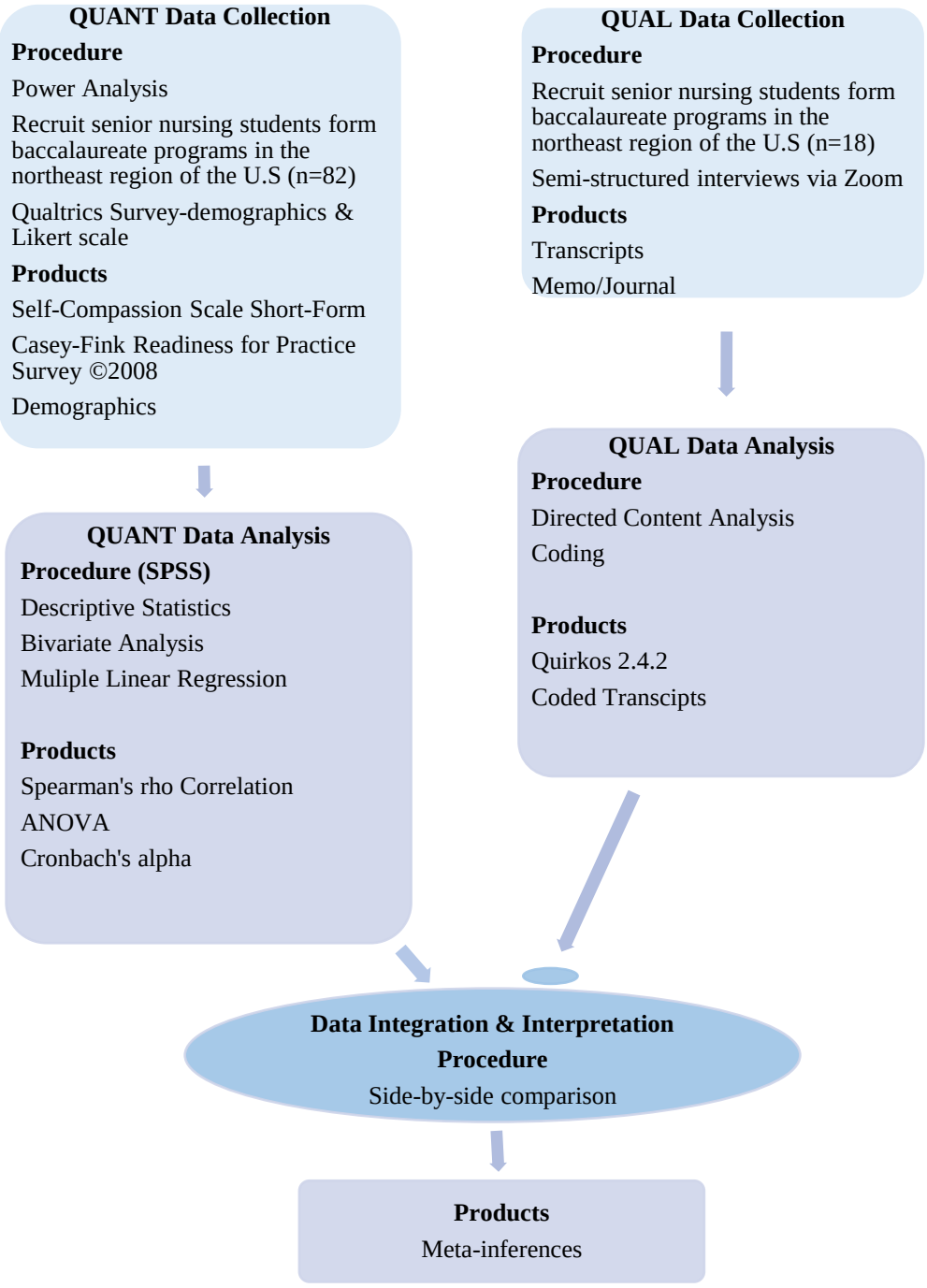

Figure 5. Convergent Mixed-Methods Procedural Design Illustration

Research Question 1

What is the relationship between nursing students' self-compassion and perceived readiness to practice? Research question one was addressed utilizing quantitative analysis. Data was collected using the SCS-SF, the Casey-Fink Readiness for Practice Survey ©2008, and a demographic survey. The quantitative analysis identified and explored the relationships between perceived readiness for practice, self-compassion, and the demographical factors of participating nursing students. Descriptive statistics depicted the percentage of demographical factors and the levels of self-compassion (58.5%= moderate) and readiness for practice (mean= 60.34, moderately high) of the participants. Based on the NLN Biennial Survey of Schools of Nursing 2019-2020, the demographical factors; age, gender, and race/ethnicity also determined if the diversity of the sample is representative of the BSN nursing student population in the United States. Based on the comparison, this study's sample was only somewhat representative of the diversity found by NLN as Black/African American students and students over the age of 23 were underrepresented.

The bivariate analysis identified significant relationships ($p < 0.05$) between the dependent variable, perceived readiness for practice, and only two of the independent variables: self-compassion, and marital status despite existing literature indicating that the independent variables: age, gender, and employment status would also have relationships with perceived readiness for practice (Guner, 2014; Luo, et al., 2019; Yang & Gysbers, 2007). These findings may be due to the sampling method and sample size which will be further discussed as a limitation. Multivariate analysis using multiple linear regression revealed that the identified relationships were predictive ($p< 0.001$), meaning

that self-compassion (+3.735) and marital status (+3.060) are predictors of perceived readiness for practice. These findings can be interpreted as for every 1 unit increase in self-compassion, perceived readiness increases by 3.735 times while holding marital status constant, and for every 1 unit increase in marital status, readiness increases by 3.060 times while holding self-compassion constant. The adjusted r square .113 shows only 11.3% of the variances are explained by this model therefore it is a weak association. See Figure 6 for the Final Linear Regression Model. The weak association may be attributed to the sample size of this study. According to Gray et al. (2017), sample size can affect relationships between variables therefore, the sampling may have affected the significance of marital status thus reducing the strength of the model.

Figure 6. Final Linear Regression Model

These predictor relationships support the hypothesis that self-compassion positively influences perceived readiness for practice and emphasizes the importance of having a support person(s). Both relationships are corroborated in the literature. Self-compassion has been shown to promote, protect and predict psychological health (Luo, et al., 2019; Shin & Lim, 2019) which increases one's resiliency towards stress, anxiety, and burnout (Fong & Loi, 2016) therefore, increasing psychological readiness (Gandhi, et al., 2021). In addition, marital status can be interpreted as a form of familial support. Christensen, et al. (2016) found that students with familial support had fewer feelings of imposterism or self-doubt and thereby, an increased sense of readiness.

Research Question 2

What are the perceptions of practicing self-compassion and its role in readiness for professional practice among nursing students? Research question two was addressed utilizing qualitative analysis. Data was collected using semi-structured interviews and analyzed using directed content analysis. The directed approach "starts with a theory or relevant research findings as guidance for initial codes" (Hsieh & Shannon, 2005, p. 1277). The qualitative analysis identified and explored the perceptions of practicing self-compassion and its role in compassionate care and perceived readiness for practice. Additional nursing program support methods to help students feel psychologically prepared for professional practice were also explored. Six themes emerged from the data. See Figure 7 for the research question, themes, and subthemes.

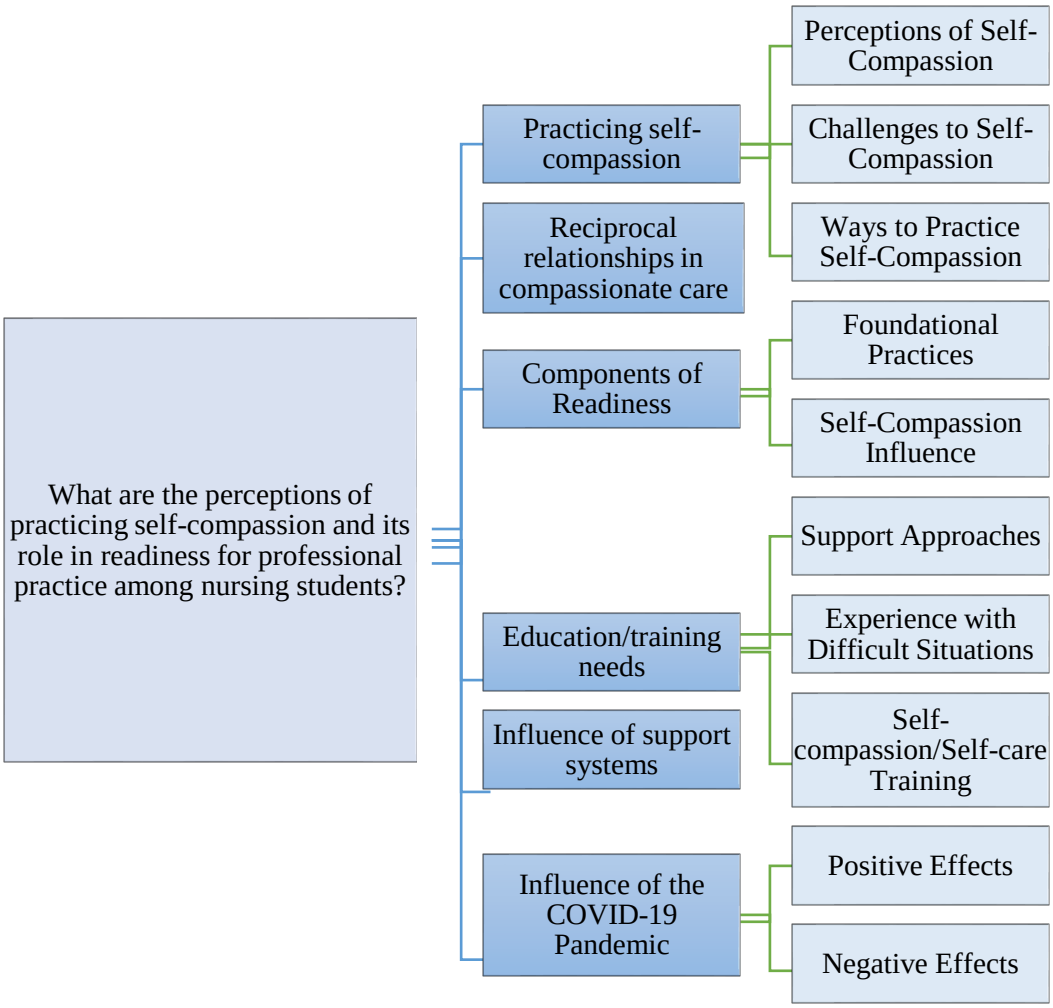

Figure 7. Research Question, Themes, and Subthemes

Participants generally perceived practicing self-compassion as challenging, particularly for nurses, yet beneficial to their psychological health and nursing practice. Practicing self-compassion was often correlated to practicing self-care; both of which were thought to enhance coping and resiliency, lower stress, and improve compassionate care. These findings are supported by the literature. Self-compassion is shown to be a predictor, promoter, and protector of psychological health (Fong & Loi, 2016; Luo, et al., 2019; Neff et al., 2007; Shin & Lim, 2019) and has proved to enhance the psychological well-being and compassionate practice of healthcare professionals (Neff et al., 2020),

however, nurses find practicing self-compassion and self-care challenging and regard them as coping mechanisms rather than ways of being (Andrews et al., 2020). Overall, participants recognized the value of practicing self-compassion against the risk of stress and burnout in professional nursing practice.

Participants recognized a reciprocal relationship between self-compassion and compassionate care. Several participants mentioned that practicing self-compassion increased compassion for others. Participants also recognized that acknowledging the humanity of others with forgiveness and love is an important aspect of nursing care that is enhanced by practicing self-compassion. This finding is supported in the literature (Linton & Koonmen, 2020; Neff et al., 2020) and by Watson's theory of human caring (2008). Watson (2008) suggests that one cannot fully care for others without caring for themselves and that caring is a way of being connected in the moment. Recognizing the humanity in others enhances the interconnectness between the caregiver and patient thus increasing the authenticity of care (Watson, 2008). Practicing self-compassion as a way of being contributes to compassionate caring practice (Linton & Koonmen, 2020; Neff et al., 2020).

Most participants perceived moderately high levels of readiness to enter professional nursing practice and the role of self-compassion was generally perceived to be a positive influence. Participants also cited foundational practices such as knowledge, skills, and self-care as positive influencers which was supported in the literature as well. Several studies have shown that senior nursing students generally perceive readiness for practice (Casey et al., 2011; Christensen et al., 2016; Guner, 2014; Usher et al., 2015). According to Mirza et al. (2019), readiness as a technical model consists of three

attributes: clinical capability, cognitive capability, and professional capability. Participants' responses suggest that knowledge relates to cognitive capabilities, skills relate to clinical capabilities and self-compassion and self-care relate to professional capabilities, which is congruent with the literature (Christensen et al., 2016; Curtis, 2014; Mirza et al., 2019). According to Ho et al. (2021), transition shock is still prevalent among new nurses. Self-compassion and self-care promote psychological well-being (Andrews et al., 2020; Neff et al., 2020) which promotes psychological preparedness and therefore readiness for professional practice (Gandhi et al., 2021).

To further promote psychological readiness, participants suggested increasing supportive education/trainings related to self-compassion, self-care, and difficult situations in practice. In general, participants recognized their programs were promoting self-care but there was a lack of education and supportive practices to promote self-compassion. In addition, there was also a lack of hands-on trainings related to difficult situations in practice. Participants felt they were more often removed from difficult situations during clinical rotations rather than being allowed to witness and experience them. Moreover, the COVID-19 pandemic affected the exposure to such situations, particularly situations that involved caring for their patients while distressed family members were present and managing situations when family or visitors become overwhelmed or threatening. Current education/trainings on self-compassion, self-care, and difficult situations were perceived as insufficient to psychologically prepare them for the stressors of professional practice. These findings are congruent with the literature (Andrews et al., 2020; Gandhi et al., 2021; Linton & Koonmen, 2020). Some researchers assert that developing self-compassion in nursing students is important for increasing

their ability to provide compassionate care and to assist them in making self-care and self-compassion common practice in addition to supporting well-being and reducing stress (Andrews et al., 2020; Linton & Koonmen, 2020). Considering the levels of stress in current nursing practice, Gandhi et al. (2021), stresses the importance of promoting students' psychological preparedness as a component of preparing them for professional practice.

Support systems were largely perceived to affect practicing self-compassion and psychological preparedness. Participants noted that family and friends encouraged developing and practicing self-compassion and self-care by providing reflection, time, and reassurance of its importance. These findings are supported in the literature. For example, Andrews et al. (2020) found that nurses often feel that they need permission to practice self-compassion and self-care and Curtis (2014) found that students experience doubt in their abilities to provide sustainable compassionate care. The support received from the participants' families and friends are in turn, giving permission to practice self-compassion which will lead to more sustainable compassionate caring practice. Participants also noted that faculty support and resources were an active component in their psychological preparedness. Some students felt a comfort in confiding in their faculty and/or other nurses since they were nurses who truly understood their feeling and concerns. In fact, it was suggested that nursing programs provide a continued support system to their new graduates to help them through their transition from student to nurse. This is an important finding, as confirmed by Fink et al. (2004) who found that new graduates experience the most stress in the first 6 months of practice. Rainbow and Steege (2018) found that self-compassion levels decrease, and stress and burnout rise

within the first 1-2 years. Many researchers have suggested further investigation on supportive measures before and during the transition from student to nurse (Andrew et al., 2020; Christensen et al., 2016; Curtis, 2014; Gandhi et al., 2021).

The timeframe for this study took place during the COVID-19 pandemic which affected the participants' perceptions of practicing self-compassion and perceived readiness. Some participants took the opportunity to reflect and attend to their needs. Slowing down allowed them to focus on self-care and develop a practice of self-compassion. However, the awareness of increased stress and rampant nursing burnout caused by the pandemic has prompted some of the participants to question their choice to go into nursing. For some, the pandemic confirmed their career choice; for others, doubts remain. Additionally, the lack of hands-on experience and communication with patient families has negatively influenced some of the participants' perceived readiness. The impacts on nursing students due to the COVID-19 pandemic has highlighted the importance of addressing psychological preparedness as part of readiness for professional practice (Aslan & Pekince, 2021; Gandhi et al., 2021). The findings of this study provide additional support for addressing psychological preparedness within the concept of readiness for practice.

There were a couple of discrepancies within the interview data. First, one participant did not believe that their self-compassion practice affected their ability to practice compassionate care stating that they were "better at understanding other people" and felt that they were able to help others easier than helping themselves. However, this statement is reflective of one of the challenges to practicing self-compassion stated by other participants compassion is often easier to have for others rather than the self. The

other discrepancy was that a participant did not identify self-compassion as influencing their readiness for practice, stating that self-compassion is something anyone can develop over time through patient interaction. Although this study contradicts this statement and shows that self-compassion does positively influence perceived readiness, there is truth within this perception. According to Neff et al. (2020), self-compassion is practiced in the moment of need and can be fostered using simple tools such as a breath or a mantra. The healthcare environment can be stressful which can often evoke the need for self-compassion (Neff et al., 2020) therefore, it is feasible that using simple techniques in moments of need, such as patient interactions, can develop self-compassion over time.

Research Question 3

To what extent do students' perceptions of self-compassion confirm outcome data on a readiness to practice measure? Research question three was addressed by integrating the quantitative and qualitative findings and conducting a side-by-side comparison. This question aimed to confirm the findings of both analyses and gain a deeper understanding of the research problem. The comparison revealed significant correlations between self-compassion and perceived readiness for practice, and between support systems, such as marital status, and perceived readiness for practice. Self-compassion and support systems were shown to positively influence readiness for practice. Findings also suggested that self-compassion increases one's ability to provide compassionate care, therefore increasing one's readiness to practice and that the COVID-19 pandemic has influenced levels of self-compassion and readiness for practice in current nursing students.

These findings support the theoretical framework of this study discussed in Chapter I and further validate Watson's theory of human caring (2008). Self-compassion

was perceived as positively influencing one's ability to connect with others and provide compassionate care. According to Watson (2008), caring is a moment or series of moments of interconnectedness between the caregiver and the care receiver. The findings suggested that self-compassion enhances students' perceived ability to share in these moments of connection with their patients, thereby increasing their perceived readiness for providing person-centered, compassionate care.

This study considered self-compassion as a proxy to psychological health which, based on the findings in this study, positively influences the ability to provide compassionate care and therefore, readiness for practice. The COVID-19 pandemic influenced practices of self-compassion and perceived readiness for the practice among nursing students, highlighting the importance of psychological health in readiness. Several studies suggest that further support is needed during nursing education to address nursing students' psychological health as a component of readiness for practice (Andrews et al., 2020; Curtis, 2014; Luo et al., 2019; Reeve et al., 2013; Senturk & Dogan, 2018). The findings of this study further support these recommendations.

Limitations and Delimitations

This study had limitations and delimitations due to the convenience sample. This study was delimited to baccalaureate nursing students in their senior year in the Northeastern Region of the United States, therefore, it may not be generalizable to all BSN students in other regions and other types of nursing programs. In addition, the study was limited to nursing students available during the 4-week data collection period which may have limited the number of participants. Further, the study was also limited to primarily female (91.5%) and White/Caucasian (73.2%) participants thus it may not be

generalizable to programs with higher percentages of male students and/or higher rates of racial/ethnic diversity. However, according to the NLN Biennial Survey of Schools of Nursing 2019-2020, students enrolled in RN programs in the United States are predominantly White/Caucasian and female.

Recommendations

Implications for Social Change

This study contributes to the growing body of literature regarding nursing students' perceived readiness for practice, concerns in their ability to provide sustainable, compassionate care (Casey et al., 2011; Curtis, 2014; Jarden et al., 2021; McVicar et al., 2021), and the influence of the COVID-19 pandemic (Aslan & Pekince, 2021; Gandhi et al., 2021). Based on the findings of this study and supporting literature, practicing self-compassion promotes psychological health (Fong & Loi, 2016; Neff et al., 2020; Shin & Lim, 2019), and enhances one's perceived readiness for practice and ability to provide compassionate care (Andrews et al., 2020; Neff, 2003b; Watson, 2008). Therefore, promoting psychological health through strategies of self-compassion development in nursing students is recommended to further prepare them to be competent as compassionate, person-centered caregivers.

In addition, the COVID-19 pandemic has influenced nursing students' perceived readiness for practice, including perceived psychological preparedness. These findings support previous suggestions that psychological health should be considered a component of nursing students' readiness for practice (Gandhi et al., 2021). Although the stressors of nursing practice have been researched in recent years (Luo et al., 2019; Reeve et al., 2013), the COVID-19 pandemic has brought nursing and nursing students' stress,

burnout, and compassion fatigue to the forefront (Aslan & Pekince, 2021; Gandhi et al., 2021). Within the current climate of healthcare, it is imperative that psychological health be addressed when considering nursing students' readiness for professional practice.

Recommendations for Action

The ability to provide person-centered compassionate care has been declared an essential competency for newly graduated nurses (AACN, 2021). Providing this care is impacted by nurses' psychological health (Kelly & Tyson, 2016; Neff et al., 2020). The findings in this study and supporting literature (Neff et al., 2020; Shin & Lim, 2019) suggest utilizing self-compassion-based strategies for improving psychological health while in nursing school. While many nursing education programs already emphasize the importance of self-care, the findings showed that the current practices are inadequate and that the concept of self-compassion is not always included. Therefore, nurse educators should consider incorporating self-compassion development throughout the curriculum to promote students' psychological health and thus the ability to provide compassionate care.

Future Research

This study contributes to the existing body of research on factors that influence readiness to practice in nursing students, self-compassion in nursing students, and the importance of psychological support throughout nursing education. Based on the literature, this study utilized the practice of self-compassion as a proxy for psychological health (Fong & Loi, 2016; Luo et al., 2019; Neff et al., 2007). The results of this study show that self-compassion, and therefore psychological health, positively influences perceived readiness for the practice among nursing students however, the association was

weak, and the generalizability was limited. Repeating this study on a larger scale, such as including participants from more than one region of the United States or including other nursing programs, is recommended to strengthen the generalizability and potentially find stronger associations.

The literature suggests that considering the COVID-19 pandemic and the increased rate of nursing burnout, psychological preparedness should be considered as a component of readiness (Gandhi et al., 2021). The results of this study support this suggestion. The creation of a new readiness instrument that includes components of self-compassion and/or psychological health is suggested to capture a more holistic picture of nursing students' readiness for professional practice. Finally, the results supported the literature that further psychological support is needed during nursing education (Curtis, 2014; Luo et al., 2019; Reeve et al., 2013; Senturk & Dogan, 2018). A review and studies of best practices of incorporating psychological support approaches, such as self-compassion development and group reflection, into the nursing curriculum is recommended.

Conclusion

This study provides new information about the concept of readiness for the practice among nursing students. As the stress of professional nursing practice rises, it is critical for nurse researchers and nurse educators to expand their understanding of what constitutes nursing students' perceived readiness. The predictive relationships between self-compassion, support, and perceived readiness endorse psychological health as a component of readiness. The development of self-compassion throughout the nursing curriculum is suggested to increase students' psychological health thereby improving

competence in providing sustainable compassionate care. An expanded understanding of readiness and additional support during students' nursing education will better prepare them to be competent as compassionate, person-centered caregivers.

APPENDIX A – 10 Caritas Processes®

1. Sustaining humanistic-altruistic values by practice of loving-kindness, compassion, and equanimity with self/others.
2. Being authentically present, enabling faith/hope/belief system; honoring subjective inner, life-world of self/others.
3. Being sensitive to self and others by cultivating own spiritual practices; beyond ego-self to transpersonal presence.
4. Developing and sustaining loving, trusting-caring relationships.
5. Allowing for the expression of positive and negative feelings - authentically listening to another person's story.
6. Creatively problem-solving-'solution-seeking' through caring process; full use of self and artistry of caring-healing practices via use of all ways of knowing/being/doing/becoming.
7. Engaging in transpersonal teaching and learning within context of caring relationship; staying within other's frame of reference-shift toward coaching model for expanded health/wellness.
8. Creating a healing environment at all levels; subtle environment for energetic authentic caring presence.
9. Reverentially assisting with basic needs as sacred acts, touching mindbodyspirit of spirit of other; sustaining human dignity.
10. Opening to spiritual, mystery, unknowns-allowing for miracles (Watson Caring Science Institute, 2021).

APPENDIX B - Self-Compassion Scale Short Form (SCS-SF)

Self-Compassion Scale Short Form (SCS-SF)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. Indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

1. When I fail at something important to me I become consumed by feelings of inadequacy.
2. I try to be understanding and patient towards those aspects of my personality I don't like.
3. When something painful happens I try to take a balanced view of the situation.
4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
5. I try to see my failings as part of the human condition.
6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
7. When something upsets me I try to keep my emotions in balance.
8. When I fail at something that's important to me, I tend to feel alone in my failure
9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm disapproving and judgmental about my own flaws and inadequacies.
12. I'm intolerant and impatient towards those aspects of my personality I don't like.

(Neff, 2021).

APPENDIX C – Casey-Fink Readiness for Practice Survey ©2008

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. I feel confident communicating with physicians.	○	○	○	○
2. I am comfortable communicating with patients from diverse populations.	○	○	○	○
3. I am comfortable delegating tasks to the nursing assistant.	○	○	○	○
4. I have difficulty documenting care in the electronic medical record.	○	○	○	○
5. I have difficulty prioritizing patient care needs.	○	○	○	○
6. My clinical instructor provided feedback about my readiness to assume an RN role.	○	○	○	○
7. I am confident in my ability to problem solve.	○	○	○	○
8. I feel overwhelmed by ethical issues in my patient care responsibilities.	○	○	○	○
9. I have difficulty recognizing a significant change in my patient's condition.	○	○	○	○
10. I have had opportunities to practice skills and procedures more than once.	○	○	○	○
11. I am comfortable asking for help.	○	○	○	○
12. I use current evidence to make clinical decisions.	○	○	○	○
13. I am comfortable communicating and coordinating care with interdisciplinary team members.	○	○	○	○
14. Simulations have helped me feel prepared for clinical practice.	○	○	○	○
15. Writing reflective journals/logs provided insights into my own clinical decision-making skills.	○	○	○	○
16. I feel comfortable knowing what to do for a dying patient.	○	○	○	○
17. I am comfortable taking action to solve problems.	○	○	○	○
18. I feel confident identifying actual or potential safety risks to my patients.	○	○	○	○
19. I am satisfied with choosing nursing as a career.	○	○	○	○
20. I feel ready for the professional nursing role.	○	○	○	○

(Casey et al., 2011).

APPENDIX D – Casey-Fink Permission of Survey Adjustment

Casey, Kathryn RN <Kathryn.Casey@dhha.org>
Thu 5/13/2021 5:45 PM

Hi Laurie- Thanks for completing the website link to access the survey.

Yes, you can use the Likert response section with the 20 questions to measure perceptions of readiness for practice. You select your time frame to measure and you have the option to use the demographic questions based on your study needs.

I'm curious… what scale are you using to measure self-compassion? It's an interesting concept to measure and we look forward to reading your results. With all the changes in education programs due to the Covid pandemic, this will be a great study!

Please let us know if you have further questions.

Warm regards,
Kathy and Regina

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Nurse Residency Program Coordinator
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Denver Health
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APPENDIX E – Definition of Self-Compassion for Interview Participants

Self-compassion is a healthy self-attitude that allows for negative feelings to transform into a more positive state (Neff, 2003). Self-compassion consists of three core components:

(a) self-kindness—being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical,

(b) common humanity—perceiving one's experiences as part of the larger human experience rather than seeing them as separating and isolating, and

(c) mindfulness—holding painful thoughts and feelings in balanced awareness rather than over-identifying with them (Neff, 2003b, p. 85).

APPENDIX F – IRB Approval Letter

Office *of*
Research Integrity

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NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

- The risks to subjects are minimized and reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI via the Incident submission on InfoEd IRB.
- The period of approval is twelve months. An application for renewal must be submitted for projects exceeding twelve months.

PROTOCOL NUMBER:	21-263
PROJECT TITLE:	Self-Compassion and Perceived Readiness for Practice Among Baccalaureate Nursing Students: A Mixed-Methods Study
SCHOOL/PROGRAM	Leadership & Advanced Nursing
RESEARCHERS:	PI: Laurie Walter Investigators: Walter, Laurie~Copeland, Debra~
IRB COMMITTEE ACTION:	Approved
CATEGORY:	Expedited Category
PERIOD OF APPROVAL:	11-Jan-2022 to 10-Jan-2023

Donald Sacco Jr.

Donald Sacco, Ph.D.
Institutional Review Board Chairperson

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