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Cardiac Patients' Perceptions of Nurse Caring Behaviors

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CARDIAC PATIENTS' PERCEPTIONS OF NURSE CARING BEHAVIORS

By

Diane Lynn Dahl

A THESIS

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ABSTRACT

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By

Diane Lynn Dahl

The purpose of this descriptive study was to identify which nurse caring behaviors were perceived by patients hospitalized with cardiac problems as being most important in making them feel cared for. The study was a replication of Larson's (1984) study using a different patient population. A convenience sample of 37 patients was obtained from a large metropolitan hospital in the midwest. The conceptual framework used for this study was Watson's Theory of Human Care. The Caring Assessment Instrument was administered by the researcher. Subjects rated nurse caring behaviors from most important to least important using Q methodology. Patients reported "being accessible" and "monitoring and following through" as most important nurse caring behaviors. Least important nurse caring behaviors included "trusting relationships" and "explains and facilitates." These results resemble Larson's (1984) study.

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Table of Contents

List of Tables.....	vi
List of Appendices.....	vii
CHAPTER	
1 INTRODUCTION.....	1
Problem Statement.....	1
Aims/Purpose.....	1
2 REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK.....	5
Review of Literature.....	5
Conceptual Framework.....	18
Implications for the Study.....	21
Research Question.....	22
Definitions.....	22
3 METHODOLOGY.....	23
Design.....	23
Study Site and Subjects.....	23
Instrument.....	24
Procedure.....	25
4 DATA/RESULTS ANALYSIS.....	27
Techniques.....	27
Characteristics of Subjects.....	27
Research Question.....	29
Ranking of Care-Q Items.....	29
Other Findings.....	29

5	DISCUSSION AND IMPLICATIONS.....	34
	Discussion of Findings.....	34
	Application to Education/Practice.....	35
	Limitations.....	36
	Suggestions for Research.....	37
	LIST OF APPENDICES.....	39
	LIST OF REFERENCES.....	49

List of Tables

Table 1.	Perceptions of the 10 most Important Nurse Caring Behaviors (Larson, 1984).....	6
Table 2.	Perceptions of the 10 Least Important Nurse Caring Behaviors (Larson, 1984).....	7
Table 3.	Most Important CARE-Q Items Agreed on by Patients and Nurses (Larson, 1987).....	10
Table 4.	Comparison of Patient and Staff Mean Scores on the Six CARE-Q subscales (von Essen & Sjoden, 1991).....	13
Table 5.	Background of Patients Participating in Study of Perceptions.....	28
Table 6.	Perceptions of the Most Important Nurse Caring Behaviors: The Ten High Mean Score CARE-Q Items.....	30
Table 7.	Perceptions of the Least Important Nurse Caring Behaviors: The Ten Low Mean Score CARE-Q Items.....	31

List of Appendices

Appendix A.	The CARE-Q Items and Scales.....	39
Appendix B	Permission to use Care-Q.....	42
Appendix C.	Consent Form.....	43
Appendix D.	Verbal Script.....	44
Appendix E.	Directions.....	45
Appendix F.	Patient Demographic Information Sheet.....	46
Appendix G.	Example of Tool.....	47
Appendix H.	Comparison of Findings of Patient's Five Most Important Nursing Caring Behaviors.....	48

CHAPTER 1

INTRODUCTION

The nursing profession is changing rapidly. The days of complacent practice are gone. It has become the time of dynamic nursing where practice today is different than yesterday and tomorrow.

Graduates from nursing programs a decade ago were secure in their professional role. Changes in their practice occurred gradually, if at all. Institutions encouraged and financially supported an all registered nursing staff. Licensed practical nurses were given tuition assistance to continue their education. Continuing education credits were also supported. The nursing shortage at that time had an effect on the nursing profession. Pay incentives and multiple job opportunities were common. Institutions spent money on finding, hiring, and maintaining nursing staff.

Today's graduate is faced with a different situation. Due to ever changing health care policies, institutions have become more cautious with their largest and most expensive employee, the nurse. The downsizing in many hospitals has created fewer jobs for nurses. The role of the professional nurse vacillates. Assessment, planning, implementation, and evaluation continue to be the core of nursing, but no longer

is the nursing process exclusive to the professional nurse. Licensed practical nurses, nursing assistants, and support staff have begun to assist in what was previously in the professional nurse's realm of practice. Decreased staffing has left nurses little time to demonstrate caring behaviors towards patients. Time spent in acute care nursing involves completing nursing tasks that although necessary, may leave the patient feeling not cared for. The curriculum for most schools of nursing contain some form of caring as an outcome. Graduates of these programs are frustrated with the decreased amount of time they have with patients to express caring.

It is important for new graduates as well as experienced nurses to demonstrate caring behaviors toward patients. Joanne R. Duffy (1990) conducted a study to measure relationships between nurse caring behaviors and outcomes of patient satisfaction, health status, length of stay, and nursing care costs in hospitalized medical and/or surgical patients. The results of the study support her hypothesis of a positive relationship between nurse caring behaviors and patient satisfaction. It was also shown that as nurse caring behaviors increased, length of stay and nursing care costs declined. Today, patient satisfaction has become the number one goal of health care with economics as the driving force. Satisfied patients will return to the same hospital if care is needed again. Patients are also effective marketing agents.

Problem Statement

The consequences of nurse noncaring behaviors can include a client that feels frustrated, scared, depressed, angry, and upset (Rieman, 1986). This is incongruent with the goals of nursing. Nursing, according to Watson (1988), is the art and science of human care, and is crucial to the recovery of critically ill patients.

Health care changes dictate a decreased amount of time spent with patients. To ensure caring remains the central focus of nursing, it is important that nurses are aware of what behaviors patients perceive as caring. Past research by Larson (1984, 1986, 1987) shows patients and nurses differ on what they consider as important nurse caring behaviors. The concept and practice of caring needs to be taught from the patient's perspective. Assessing what patients feel are caring behaviors should be emphasized. A priority in health care today is patient satisfaction. This outcome can be reached if nurses are able to assess and demonstrate the caring behaviors patients perceive as important.

Aims/Purpose

The purpose of this study was to determine which nurse caring behaviors were perceived by cardiac patients as being most important or least important, and those caring behaviors that most clearly convey to the patient a subjective feeling of being cared for. Exploring different patient populations assisted in expanding knowledge obtained

from previous studies to see if results are universal among all patients. The results of this study may have implications for teaching of caring in schools of nursing. The results also may assist practicing nurses to make decisions regarding nurse caring behaviors they use with patients. Changes dictated by health care policies have left nurses less time to demonstrate caring behaviors. Nurses need to be aware of the potential differences between their perceptions and patient's perceptions of caring when assessing patients. An accurate assessment of patients' needs leads to awareness of appropriate care and comfort measures and affects patient satisfaction. Nurses will need to be able to decide which caring behaviors patients feel are most beneficial.

CHAPTER 2

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Review of Literature

Several studies have analyzed patient's perceptions of caring using a variety of methods. Both acute and chronically ill patients have been surveyed. Staff perceptions of caring were also analyzed and compared with patient's perceptions of caring. Tools used included the Caring Assessment Instrument (CARE-Q), modified versions of the CARE-Q, and the Caring Behaviors Assessment.

Larson (1984) completed an analysis of a convenience sample of 57 adult cancer patients, hospitalized for treatment, using the Caring Assessment Instrument (CARE-Q). The CARE-Q examines patient's perceptions of nurse caring behaviors by ranked importance.

The means of the 50 CARE-Q items ranged from 5.04 for the most important item ("knows how to give shots, intravenous, etc., and how to manage equipment") (see Table 1) to 2.93 for the least important items ("asks patients what name they prefer to be called") (See Table 2).

Table 1

Perceptions of the 10 Most Important Nurse Caring Behaviors

CARE-Q subscale	CARE-Q item	M	SD
Monitors/Follows Through	Knows how to give shots, I.Vs, etc., and how to manage the equipment	*5.04	1.34
Monitors/Follows Through	Knows when to call the doctor	4.84	1.22
Accessible	Responds quickly to patient's call	4.61	1.15
Monitors/Follows Through	Gives good physical care to patient	4.60	0.98
Accessible	Gives the patient's treatments & medications on time	4.56	1.12
Trusting Relationship	Puts patient first no matter what else happens	4.54	1.38
Comforts	Listens to patient	4.47	1.01
Comforts	Talks to patient	4.37	1.01
Accessible	Checks on patient frequently	4.35	1.03
Monitors/Follows Through	Is well-organized	4.35	1.14

Adapted From "Patients' perception of caring," by

P.J. Larson, 1984, Oncology Nursing Forum, 11, p.49.

*mean score from a range of 1(least important) to 7(most important)

Table 2

Perceptions of the 10 Least Important Nurse Caring Behavior

CARE-Q Subscale	CARE-Q Item	M	SD
Accessible	Volunteers to do "little" things for patient	*3.63	1.16
Trusting Relationship	When with patient, concentrates only on that patient	3.60	1.25
Trusting Relationship	Helps patient establish realistic goals	3.60	1.12
Explains/ Facilitates	Tells patient of available support systems	3.53	1.05
Comforts	Is patient even with difficult patients	3.46	1.12
Trusting Relationship	Offers reasonable alternatives	3.46	1.15
Monitors/Follows Through	Is professional in appearance	3.39	1.26
Comforts	Sits down with patient	3.39	1.33
Trusting Relationship	Checks out the best time to talk with the patient about changes in physical condition	3.32	1.04
Trusting Relationship	Asks patient what name he/she prefers to be called	2.93	1.41

Adapted From "Patients' perceptions of caring," by

P.J. Larson, 1984, Oncology Nursing Forum, 11, p. 50.

*mean score from a range of 1(least important) to 7(most important)

For the majority of patients in this study, demonstrated competency of skills precedes the patient's need to be listened to by the nurse. Larson cautions nurses who care for cancer patients not to assume that intended caring is always perceived by the patient as caring. Limitations of the study were related to Q methodology, the CARE-Q instrument, and validity and reliability concerns. Larson and Ferketich (1993) felt the length of the tool might be challenging to patients, especially acutely ill patients that can tire easily. A possibility was present that 50 items might include a duplication. The methodologic format of the CARE-Q limits the instruments use to ranking caring behaviors from important to unimportant. This forced choice may have influenced the results by not allowing equal choices for all the items.

Larson (1986) also studied a convenience sample of 57 registered oncology nurses from two hospitals in the Northwest using the CARE-Q. The means for the 50 CARE-Q items ranged from 5.9 for the most important rank item ("listens to the patient") to 2.5 for the least important item ("is professional in appearance"). The study results reveal that nurses' perceptions are not in agreement with patients' perceptions of caring. In Larson's (1984) previous study, cancer patients identified nurse behaviors that represent monitoring and follow-through and being accessible as most important. Listening, ranked most important by nurse participants, was ranked seventh in

importance by the cancer patients. The forced choice format of Q methodology was difficult for most participants. Two issues were raised. One was that nurses may consciously perceive caring differently from how they think patients perceive caring and that the nurses may have sorted the cards the way they felt they should, rather than how they really felt. These issues raise a question about the validity of the results.

A descriptive comparative study was completed by Larson (1987) comparing cancer patients' and professional nurses' perceptions of important nurse caring behaviors. The subjects were a convenience sample of registered nurses interacting with oncology patients in a hospital setting ($N = 57$) and cancer patients hospitalized for treatment ($N = 57$). The CARE-Q was administered and analyzed. It was found that patients valued items categorized under the "Monitors and Follows Through" significantly more than nurses did $F(1,112) = 30.25, p < .0001$. Nurses valued significantly more than patients did the items categorized under "Comforts" subscale $F(1,112) = 33.9, p < .0001$ and under the "Trusting Relationship" subscale $F(1,112) = 5.80, p < .0177$ (See Table 3).

Analysis of the data revealed that the cancer patients and nurses in this study had significantly different perceptions of almost 38% (19 of 50) of the CARE-Q items.

Table 3

Most important CARE-Q items agreed on by patients and nurses

	Patients		Nurses	
	M	SD	M	SD
Accessible subscale				
Gives quick response to patient's calls	*4.6140	1.1457	*4.5087	1.1039
Comforts subscale				
Listens to patient	4.4736	0.9378	5.8696	0.9531
Talks to patient	4.3684	1.0112	4.7017	1.1796
Trusting relationship subscale				
Puts patient first no matter what	4.5438	1.3767	4.4736	1.6808
Monitors and follows through subscale				
Gives good physical care to patient	4.5964	0.9794	4.4661	0.8774

Adapted From "Comparison of cancer patients' and professional nurses' perceptions of important nurse caring behaviors," by P.J. Larson, 1987, Heart & Lung, 16, p. 191.

*mean scores from a range of 1 (least important) to 7 (most important)

In a replication study originally conducted by Larson (1981), Mayer (1987) used the CARE-Q instrument and comparable patient (N = 54) and nurse (N = 28) samples. The above results were substantiated. The correlation of the six mean categories between Mayer and Larson patients was $r = .87$, $p = 0.248$ and between nurses was $r = .66$, $p = 0.1562$.

One hundred percent of the nurses' and 40% of the patients' most important caring behaviors parallel those of Larson. There was also agreement with Larson's data in the least important behaviors in 100% of the nurses' choices and 80% of the patients.

von Essen and Sjoden (1991) completed a similar study in 1990 using a Swedish version of the CARE-Q. Differences included a patient population consisting of cancer (N = 35), general surgical (N = 26), and orthopedic (N = 20) patients. Staff sorting the CARE-Q included nurses (N = 51), nurse assistants (N = 33), and nurse aides (N = 20). Patients and staff were each presented as one group after differences were analyzed. Patient and staff perceptions differed significantly on almost 60% of the individual CARE-Q items. Again, results suggest that patients perceive technical/instrumental items to be more important than staff and staff value expressive/affective items higher than patients. The findings support previous research by Larson (1986) and Mayer (1987) where patients identified nurse behaviors that represent monitoring and following through and being accessible as most important. The authors feel "the identified nurse caring behaviors and caring dimensions provide a preliminary basis for a prescriptive theory of caring.... They [prescriptive theories] are crucial to caring because they allow nursing staff to predict outcomes and prescribe interventions based on knowledge of the consequences of the intervention" (p. 280).

von Essen and Sjoden (1991) replicated the above study using medical patients (N = 43) and surgical patients (N = 43) from a county and university hospital. Staff consisted of nurses (N = 39) and nurse aides (N = 34) with equal representation from each hospital and nursing unit. Half of the patients and staff groups were administered the CARE-Q. The other half used a questionnaire constructed by the authors containing the 50 CARE-Q items with a Likert scale from one to seven points for each behavior. CARE-Q results indicate significant patient - staff differences on three of six subscales (see Table 4). Patients assigned higher values to "Monitors and Follows Through" and "Explains and Facilitates" subscales. The staff scored higher on the "Comforts" subscale. There were significant differences between patients and staff for 14 out of 50 items.

Results from the study using the questionnaire showed significant patient - staff differences on five of six subscales and staff gave significantly higher values to 30 of the items. Comparison of the CARE-Q to the questionnaire showed a rank correlation of 0.83 for patients and 0.82 for staff. Patient - staff agreement was higher with caring behaviors deemed least important. Medical verses surgical patients and staff did not differ significantly in the importance they assigned to CARE-Q subscales. The authors felt that several of the items were non-specific with

Table 4

Comparison of patient and staff mean scores on the six CARE-Q subscales

Subscale and patient rank	Patients M	Staff M	Staff rank	t
1. Explains and facilitates	4.13	3.85	6	2.97*
2. Monitors and follows through	4.08	3.85	4	2.03*
3. Anticipates	4.07	4.08	2	0.01
4. Comforts	4.07	4.46	1	4.11*
5. Trusting	3.89	3.86	5	0.64
6. Accessible	3.88	4.00	3	1.25

Adapted From "Patient and staff perceptions of caring: review and replication," by L. von Essen & P.-O. Sjoden, 1991, Journal of Advanced Nursing, 16, p. 1367.

*significant difference

-mean scores from a range of 1(least important) to 7(most important)

respect to the behaviors they referred to which may lead to a variety of interpretations. They also felt that the items used were within the construct of 'care', but do not necessarily cover it completely.

A descriptive study by Rosenthal (1992) looked at both patients' and nurses' perceptions of important nurse caring behaviors using a different patient and nurse population. A convenience sample of 30 coronary patients and 30 critical care nurses were recruited from three hospitals in a large metropolitan western city. The CARE-Q was used for both groups and both felt restricted by the forced choice format of the Q methodology. Results of the study showed patients

perceived instrumental care as the most important nurse caring behaviors, whereas nurses perceived expressive care as most important. These results support the findings of Larson's (1984, 1986, 1987) previous studies. Rosenthal feels Maslow's hierarchy of needs may explain the patients' emphasis on safety and security as the patients deal with basic needs.

Keane, Chastin, and Rudisil (1987) studied nurses ($N = 26$) and patients ($N = 26$) from a rehabilitation hospital in the southeast using the CARE-Q. Both groups identified nurse behaviors that represent "Monitors and Follows Through" and "Is Accessible" as most important subscales. Spearman's correlation coefficient for ranked data of both groups was $+0.94$. A major difference between patients and nurses was the patients' emphasis on "Anticipates Needs." Compared to the previous studies mentioned, the nurses' results differed in that rehabilitation nurses emphasized self-care practices and active participation before effective behaviors. The authors agree that "findings of this study support Larson's (1984) recommendation that the greatest implication for practice is for nurses to validate the effect their intended caring has on patients." (p. 184)

Cronin and Harrison (1988) used the Caring Behaviors Assessment (CBA) and replies to an open ended question to identify caring nursing behaviors. Hospitalized patients who had a myocardial infarction ($N = 22$) participated in the

study. The participants were asked the question, "While in the coronary care unit, what things did nurses say or do that make you feel cared for and about?" (p. 377) The CBA was developed by the investigators and lists 61 nursing behaviors ordered in seven subscales that are congruent with Watson's carative factors (Watson, 1979). Subjects were asked to indicate the degree to which each behavior communicated caring to them on a five point Likkert-type scale. Face and content validity were established by a panel of four content specialists familiar with Watson's (1979) conceptual model. Internal consistency reliability was determined for each of the seven subscales. Cronbach's alphas ranged from 0.66 to 0.90. Overall item means for each of the seven subscales were calculated. The highest ranked subscale was "Assistance with gratification of human needs ($M = 4.60$)," which includes items such as knows how to handle equipment, checks patients condition closely, and lets family visit as much as possible. The authors did not give specific data regarding the responses to the open-ended question. Limitations of this study included the small sample size and the relative homogeneity of the group. Limitations of the tool included its length and the variability in number of items per subscale. The open-ended question asked for two answers, "cared for" and "about" which is a limitation. The results of this study are similar to those reported by Brown (1986), Larson (1984), and Mayer (1987).

Emergency department patients' perception of nurse caring behaviors was studied by Huggins, Gandy, and Kohut (1993). The subjects were ambulatory patients treated in the emergency department, emergent (N = 81), urgent (N = 99), and nonurgent (N = 108), from two private hospitals. A modified version of the CBA was used. The modified tool contained 53 nursing behaviors that patients rated on a four-point ordinal scale from unimportant (1) to an absolute must (4). Several statements were altered to be more appropriate to the patients' experience in the emergency department. Six subscales were used, from one to six: Humanism/faith-hope/sensitivity; Helping/trust; Expression of positive/negative feelings; Teaching learning; Supportive/protective/corrective environment; and Human needs assistance. The instrument was pilot tested by the first 20 participants. Cronbach's Alpha and internal consistency values were comparable to the Cronin and Harrison (1988) study. The results support the findings from the Cronin and Harrison study. Subscale six, human needs and assistance was rated by all patients, regardless of their triage category, as most important for determining nurse caring behaviors. This subscale is composed of behaviors reflecting the nurses' technical competency. Limitations of the study were that only patients with telephones were included, patient proxies were used, and the time between the emergency department visit and data collection may have affected the recall of some patients.

Brown (1986) asked fifty hospitalized medical or surgical patients to describe an experience in which they felt cared for by a nurse. After these incidents were analyzed, eight care themes were found: Recognition of individual qualities and needs, reassuring presence, provision of information, demonstration of professional knowledge and skill, assistance with pain, amount of time spent, promotion of autonomy, and surveillance. Two patterns of combined themes were: Demonstration of professional knowledge and skill, surveillance and reassuring presence; recognition of individual qualities and needs, promotion of autonomy and time spent. Time spent was an underlying theme in the majority of incidents. Brown spoke of a four-part process of care that emerged from the analysis of the reports. The first component was a patient perception of a need. Recognition and acknowledgement by the nurse was second, action taken and how the action is performed were the third and fourth components. Brown states "fundamental to the experience of care is the patients confidence in the ability of the nurse to provide the necessary physical care and treatment. As this professional competency is demonstrated, the more expressive activities become important." (p. 62)

Summary

Research on caring behaviors has included several types of patients with chronic and acute responses to illness. Results from the studies reviewed show that patients perceived instrumental behaviors as most important while nurses perceived expressive behaviors as most important regardless of the instrument used. The results support Larson's (1984, 1986, 1987) research which states that patients and nurses may differ in their perceptions of caring.

Conceptual Framework

The framework used for this study was Watson's Theory of Human Care (1988). Watson defines human life as "(spiritual-mental-physical) being-in-the-world, which is continuous in time and space. Only to the extent that a person has fulfilled the concrete meaning of human existence will the self be fulfilled; the meaning that a being has to fulfill is something beyond the self, it is never just self." (p. 47) Illness is described as disharmony within a person's inner self or spheres, for example, mind, body, and soul. A troubled inner soul can lead to illness, and illness can produce disease. Health refers to unity and harmony within the mind, body, and soul. The goal of nursing is to "help persons gain a higher degree of harmony within the mind, body, and soul which generates self-knowledge, self-reverence, self-healing, and self-care processes while allowing increasing diversity." (p. 49)

Nursing consists of knowledge, thought, values, philosophy, commitment, and action, with some degree of passion. These are related to human care transactions. Watson discusses phenomenal field which is the individual's frame of reference that can only be known to that person. An actual caring occasion involves action and choice both by the nurse and the individual. This can lead to transpersonal caring in which the nurse can enter into the experience of another person, and another can enter into the nurse's experience.

The goals for the theory ideals are associated with mental-spiritual growth for self and other, finding meaning in one's own existence and experiences, discovering inner power and control, and potentiating instances of transcendence and self-healing. Agent of change is viewed as the individual patient, but the nurse may be a coparticipant in change through the human care process.

Interventions are related to the human care process with full participation of the nurse/person with the patient/person. "Human care requires knowledge of human behavior and human responses to actual or potential health problems; knowledge and understanding of individual needs; knowledge of how to respond to others' needs; knowledge of our strengths and limitations; knowledge of who the other person is, his or her strengths and limitations, the meaning of the situation for him or her; and knowledge of how to comfort, offer compassion and empathy." (p. 74).

Watson states interventions require an intention, a will, a relationship, and actions. These interventions can be referred to as carative factors (Watson, 1979) and include:

1. humanistic-altruistic system of values
2. faith-hope
3. sensitivity to self and others
4. helping-trusting, human care relationship
5. expressing positive and negative feelings
6. creative problem-solving caring process
7. transpersonal teaching-learning
8. supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. human needs assistance
10. existential-phenomenological-spiritual forces.

The carative factors listed can become actualized in the human care process. The degree of caring is influenced by multiple, complex forces. Different nurses and different moments allow for higher levels of caring.

The importance of being aware of patient's perceptions of nurse caring behaviors is supported by Watson's (1988) theory of human care. She clearly states in her theory that human care requires knowledge and understanding of individual needs, how to respond to other's needs, and how to comfort, offer compassion, and empathy. Past research shows that nurse's perceptions of caring differ from

patient's perceptions of caring. This could mean that nurses are not assessing patients for what patients feel are the best interventions to make them feel cared for. Nursing places importance on expressive behaviors, for example, listening and touch. These caring behaviors have been taught to them in nursing schools as caring interventions. Although these are important nursing interventions, if they aren't considered important by the patient, the patient will not feel cared for. Basic human care requires nurses to have knowledge and understanding of the patient's needs. If nurses are not assessing patients accurately, basic human care cannot occur.

For Watson, the technical interventions described by patients in the previous studies as being the most important caring behaviors would be considered a lower level of caring. As stated earlier, human care does require knowledge and understanding of individual needs. It is important for nurses to be aware of and meet these needs so patients and nurses can move to a higher degree of caring. The more human care is actualized, the more potential the caring holds for human health goals to be met (Watson, 1988).

Implications for the Study

Past research on caring has provided a beginning knowledge base for further research. The study of the concept of caring appears to be complex and difficult to measure. Previous studies using the CARE-Q have identified

the tool's limitations. Because the length of the tool has made it difficult for some patients to complete, offering assistance, allowing the patient to complete the tool over a longer time period, and administering the tool around the patient's schedule should make it easier for the patient to complete the tool. Some patients have also admitted frustration with using the Q-methodology.

Research Question

The question addressed in this study was: Which nurse caring behaviors are perceived by hospitalized patients with cardiac problems as being most important in making them feel cared for?

Definitions

1) Nurse caring behaviors: The acts, conduct, and mannerisms enacted by professional nurses that convey to the patient concern, safety, and attention as identified by Larson (1984) (see Appendix A).

2) Feeling cared for: The sensation of well-being and safety that is the result of enacted behaviors of another. Assumption: The sensation in patients of "feeling cared for" results from nurses' caring behaviors as identified by Larson (1984)

CHAPTER 3

METHODOLOGY

Design

This descriptive study was a replication of Larson's (1984) study of identifying patients' perceptions of caring. Information was obtained from hospitalized cardiac patients using the CARE-Q developed by Larson (1984). Nurse caring behaviors that patients feel are most important were identified.

Study Site and Subjects

A convenience sample of adult patients who have been admitted to a 38 bed step-down telemetry unit from a large metropolitan hospital in the Midwest was obtained. All clients with a medical diagnosis of myocardial infarction, rule out myocardial infarction, coronary artery disease, and congestive heart failure were considered. The patients had the ability to speak and understand English. The patient's primary nurse assessed the patient's physical and mental ability to participate in the study. Only patients who had been approved by their primary nurse were asked to participate in the study.

Instrument

The CARE-Q is based on the forced-choice Q-sort method which yields a priority ranking of 50 behaviors. Based on the results of two studies, Larson identified 60 behaviors as representative of caring, and based on validity and reliability studies, 50 behaviors were categorized into the following six subscales: Accessible (6 items); explains and facilitates (6); comforts (9); anticipates (5); trusting relationship (16); and monitors and follows through (8). The CARE-Q packet contains seven pockets, each labeled with a number (1,4,10,20,10,4,1) and a deck of 50 cards, each with a different nurse caring behavior typed on it. To identify the nurse caring behaviors perceived as most important, the deck of 50 cards is sorted by placing each card into one of the pockets from most important to least important. One card is placed in the pocket showing number 1, four cards in pocket 4, etc. Each pocket is coded for analysis from seven to one, most important to least important (see Appendix A & G).

Larson (1984) reported face and content validity of CARE-Q through the use of review panels of doctoral students, nurse faculty, staff nurses, and patients. The Expert Nurse Panel addressed 69 items for:

1) classification of behavior to caring theme; 2) content validity of each behavioral statement as being representative of the caring concept of nursing; and, 3) clarity of the statement into understandable terms. The

Expert Nurse Panel and a psychometrician eliminated items which did not gain consensus and items of similar intent were combined. This resulted in 52 item statements for final review by a panel of patients and nurses. Review by this panel resulted in two items being deleted.

Reliability was established through test-retest studies. The first study was based on a sample of ten undergraduate students and resulted in a perfect correlation between Test 1 and Test 2 ($r:1.0$) on the items selected as most important and least important. The sample for the second test-retest study were 82 members of the Oncology Nursing Society. Consistency of the five most important items was 79.1% and 63.4% for the five least important items (Larson, 1984). The findings of Mayer (1987) also support the reliability of the tool.

Procedure

Approval was obtained by the Human Subjects Review Committee at Grand Valley State University and the hospital. Permission to use the CARE-Q was obtained from P. Larson (see Appendix B). The CARE-Q was administered by the researcher over a one month period. The researcher verbally introduced herself and explained the purpose of the study (see Appendix D). A consent form was signed, written instructions and procedures were explained if the patient agreed to participate in the study (see Appendices C & E). Patient rights were protected (see Appendix C). There were no anticipated discomforts, risks, or benefits. Demographic

data were obtained (see Appendix F). The subjects chose assistance or sorted through the items on his/her own. The researcher returned in 15 minutes to answer any questions and in one hour to pick up the completed tool.

Chapter 4

DATA/RESULTS ANALYSIS

Techniques

Each participant's item CARE-Q was numerically coded for statistical analysis. The one most important item was coded as a seven (7). The four next most important items were coded as six (6) and the ten items identified as being also important were coded as five (5). The twenty middle items were coded four (4). The ten items perceived as being less important were coded as three (3). The four items identified as being next to least important were coded as two (2) and the least important item was coded as one (1). Means and standard deviation were calculated.

Characteristics of Subjects

Forty-two patients, hospitalized on a step-down telemetry unit, agreed to participate in the study. Thirty-seven patients completed the tool and were included in the convenience sample. There were twice as many male patients as female patients. Ages ranged from 18 years to over 65 years with a majority of patients over 51 years of age. Most patients were either high school or college graduates dividing work status between full-time and not employed. Those not completing the tool were unable to place the designated number of cards in the pockets (N = 6).

The patient demographic information is presented in table 5.

Table 5

Background of Patients Participating in Study of Perceptions
(N = 37)

VARIABLE	NUMBER	PERCENT
DIAGNOSIS		
Myocardial Infarction	7	19%
Coronary Bypass	8	22%
Angina	8	22%
Congestive Heart Failure	5	14%
"Heart Problems"	9	23%
AGE		
18 to 35 years	2	5%
36 to 50 years	7	19%
51 to 65 years	11	30%
65 years +	17	46%
GENDER		
Male	25	67%
Female	12	33%
WORK STATUS		
Full-time	15	41%
Part-time	3	8%
Not-employed	18	50%
No response	1	1%
EDUCATIONAL BACKGROUND		
Elementary	4	11%
High school	14	38%
College	17	46%
Graduate School	2	5%

Research Question

The question addressed in this study was: Which nurse caring behaviors are perceived by hospitalized cardiac patients as being most important in making them feel cared for?

Ranking of the CARE-Q Items

Subjects identified the item "Knows when to call the doctor" as most important and "Tells the patient of support systems available, such as self-help groups or patients with similar disease" as least important.

Four of the ten items ranked as most important were in the "Accessible" subscale; four items were in the "Monitors and Follows Through" subscale; two items were in the subscale "Comforts"; and one item in the subscale "Trusting Relationships" (see Table 6).

Four of the ten items ranked as least important were from the "Trusting Relationships" subscale. Two items were from "Explains and Facilitates" subscale and two items were from "Comforts" subscale. The remaining two least important items were from the "Accessible" and "Monitors and Follows Through" subscale (see Table 7).

Other Findings

The sample was divided into three groups; bypass (N = 8), angina (N = 8), and myocardial infarction (N = 7). The means of these groups were compared. The groups agreed

Table 6

Perceptions of the Most Important Nurse Caring Behaviors:
The Ten High Mean Score CARE-O Items (N=37)

CARE-Q Subscale	Item	M	SD
Monitors/Follows Through	Knows when to call the doctor	*5.51	.99
	Gives good physical care	5.12	1.32
	Knows how to give shots, I.V.s, etc., and how to manage equipment	5.05	1.35
Accessible	Gives the patients treatments & medications on time	5.03	1.01
	Responds quickly to patients call	5.03	1.04
	Checks on patient frequently	4.84	.87
Trusting Relationships	Puts patient first no matter what else happens	4.78	1.29
Comforts	Listens to patient	4.62	1.23
Accessible	Encourages patient to call with problems	4.59	1.01
Comforts	Is cheerful	4.41	1.21
Monitors/Follows Through	Is well organized	4.41	1.04

*mean score from a range of 1 (least important) to 7 (most important).

Table 7

Perceptions of the Least Important Nurse Caring Behavior:
The Ten Low Mean Score CARE-Q Items (N=37)

CARE-Q Subscale	Item	M	SD
Explains/ facilitates	Tells patient of support systems available	*3.14	.95
Trusting Relationships	Gets to know patient as individual person	3.25	1.33
	Offers alternatives to patient	3.27	.93
	Asks patient what name she prefers to be called	3.27	1.31
Explains/ Facilitates	Helps patient not feel dumb by giving adequate information	3.30	.94
Accessible	Volunteers to do "little" things for patient	3.32	1.30
Comforts	Sits down with patient	3.41	.99
Monitors/Follows Through	Is professional in appearance	3.43	1.12
Comforts	Touches the patient	3.46	1.24
Trusting Relationships	Checks out the best time to talk with patient about changes in physical condition	3.49	.84

*mean score from a range of 1 (least important) to 7 (most important).

on four of the ten most important items and three of the ten least important items. "Knows when to call the doctor", "Gives good physical care", "Puts the patient first, no matter what else happens", and "Checks on the patient frequently" were listed under the ten most important items in all three groups. All three groups agreed that "Knows when to call the doctor" was the most important item.

Agreement on the ten least important items included: "Tells the patient of support systems available, such as self-help groups or patients with similar disease", "Helps the patient not feel dumb by giving him/her adequate information", and "Touches the patient when he/she need comforting". Angina and bypass patients agreed on the least important item ("Tells the patient of support systems available"). Myocardial infarction patients felt "Volunteers to do 'little' things for the patient" was the least important item.

Means were calculated dividing the group into males ($N = 25$) and females ($N = 12$). Both groups agreed on seven of the ten most important items. Females rated "Knows how to give shots, I.V.'s, etc. and how to manage the equipment like I.V.'s, suction machines, etc." as most important ($M = 5.58$) while males ranked it seventh ($M = 4.8$). Males ranked "Knows when to call the doctor" as most important ($M = 5.68$) and females ranked this fourth ($M = 5.17$).

Both groups also agreed on six of ten least important items. Females felt "Asks the patient what name he/she

prefers to be called" was least important ($M = 3.08$) while males chose "Tells the patient of support systems available, such as self-help groups or patients with similar disease" as least important ($M = 2.96$).

The subjects were divided into two groups: Those with a high school education or less ($N = 18$) and those with a college or graduate education ($N = 19$). Both groups agreed on eight out of the ten most important nurse caring behaviors. "Knows when to call the doctor" was chosen as the most important behavior by both groups.

The two groups agreed on seven out of ten least important caring behaviors. Those with a high school education or less chose "Volunteers to do little things for the patient" ($M = 3.00$) as least important. Subjects with a college or graduate education stated "Touches the patient when he/she needs comforting" ($M = 3.16$) as least important. The least important item of one group is not found in the least important items of the other group.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Discussion of Findings

The subjects in this study reported "being accessible" and "monitoring and following through" as most important nurse caring behaviors. These findings resemble Larson's (1984) study with agreement on eight of the ten most important items and Larson's (1987) study with agreement on nine of the ten most important items. von Essen and Sjoden (1991 & 1991) show agreement in six and five out of the ten most important items. Mayer (1987) reported five most important items, four of which were in agreement with this study. Keane, Chastain, and Rudisil (1987) showed agreement with seven out of the ten most important items. The order of top ten/five items differed between studies (see Appendix H).

Past research has shown differences between patients' and nurses' perceptions of caring behaviors. Despite a difference in patient populations, findings from this study resemble many other studies. Watson's (1988) theory of human care stresses that basic human care requires knowledge and understanding of individual needs. It is important that assumptions are not made by nurses on what patients perceive as caring behaviors. Nurses need to continuously assess and

listen to patients to be able to participate as an agent of change with the patient. If this nurse/patient relationship occurs, the greater the possibility of human health goals being met.

Competency of skills and being accessible are nursing behaviors ranked highly by patients in this study and in previous studies using the CARE-Q. It would be expected that cardiac patients would rank these behaviors higher. Cardiac patients require technically skilled nurses that are able to handle multiple I.V.'s, medications, and monitors. Patients on a telemetry unit are also monitored more frequently than on a general unit. It is important for patients to know nurses are accessible if chest pain or other critical complications arise.

Application to Education/Practice

An important part of nursing curriculum is caring. Some schools base their entire curriculum on caring. It has been taught as a concept as well as an intervention. Emphasis has been placed on areas represented in the "Comforts", "Explains and Facilitates", and "Trusting Relationships" subscales when caring is taught to students. Although these concepts and interventions are important, this study and previous studies have shown that they are not what patients perceive as most important. Students need to be taught not only about caring concepts and interventions, but how to assess patients for what patients perceive as important nurse caring behaviors.

It is important that this knowledge is applied to practice. As stated earlier, nurses have less time to care for patients. This time needs to be used in the best possible way to make patients feel cared for. Assessment of what nursing behaviors patients feel are important is crucial to patient satisfaction - a primary goal of health care.

Limitations

This study required subjects to be alert and orientated and have the ability to complete a lengthy tool. This can be difficult in an acute care setting where patients are older and sicker than ever before. This made obtaining a convenience sample difficult. This sample excluded many of the patients on the unit. Results are not representative of the total population of patients hospitalized with a cardiac problem. The moderate sample size ($N = 37$) also requires caution to generalize the results.

The subject's methods of completing the tool may have affected the results. Directions were given to complete the tool without assistance. Because of the length of the tool, the likelihood of family/visitors being present during tool completion was high. Assistance may have been given to the patient which could affect the outcome.

Many subjects would not write the diagnosis of their condition on the demographic sheet or stated "heart problems." If patients had been more specific about their diagnosis, a larger group could have been analyzed. The

subject diagnosis should have been obtained from their records.

Subjects expressed some difficulty with the tool and methodology. As stated earlier, some subjects were unable to place the right number of cards in the designated pockets. Many subjects stated that all the behaviors were important and had difficulty rating them. One subject felt the behaviors were not only nursing behaviors, but physician behaviors as well. Some subjects completed the tool quite quickly (within 15 minutes) while others took several hours.

Suggestions for further research/modifications

This study as well as other studies on perceptions of caring using the CARE-Q did not identify different levels of nursing. It would be interesting to study nursing behaviors of nurse aides, licensed practical nurses, associate degree, diploma, bachelors, and advanced degree nurses separately using the CARE-Q. Does the educational preparation of a nurse affect patients' perceptions of feeling cared for?

As stated above, it was difficult to obtain a convenience sample. Using more than one hospital would have facilitated obtaining a larger sample size. A larger sample could be obtained from studying "well" patients, for example, obstetrics or rehabilitation.

It would be interesting to study how nurses define caring. Is it actually the essence of their total practice or is it broken down into segments of care, caring, caring for, and caring about? Are all nursing behaviors caring?

Larson and Ferketich (1993) have expanded on Larson's (1984, 1986, & 1987) previous research. The Care/Satisfaction Questionnaire (CARE/SAT) is the fourth phase of research by Larson that focuses on the concept of caring. This tool allows assessment of whether the patients actually experienced the caring of nursing which differs from the CARE-Q which ranks important nurse caring behaviors. The instrument contains 29 questions measured using a visual analogue scale with behaviors in three subscales: "Benign Neglect", "Enabling", and "Assistive". The tool has had initial testing and needs further administration to address the issue of concurrent validity.

The study of caring is very complex. It is difficult to measure because of its' complexity. Continued research such as Larson & Ferketich (1993) will increase the ability to measure caring, thus increasing the knowledge of this concept.

LIST OF APPENDICES

Appendix A

The CARE-Q Items and Scales

Subscale: Accessible

Items:

1. Frequently approaches the patient first, e.g., offering such things as pain medication, back rub, etc.
2. Volunteers to do "little" things for the patient, e.g., brings a cup of coffee, paper, etc.
3. Gives the patient's treatments and medications on time.
4. Checks on the patient frequently.
5. Gives a quick response to the patient's call.
6. Encourages the patient to call if he/she has problems.

Subscale: Explains and Facilitates

Items:

7. Tells the patient of support systems available, such as self-help groups or patients with similar disease.
8. Helps the patient not feel dumb by giving him/her adequate information.
9. Tells the patient, in understandable language, what is important to know about his/her disease and treatment.
10. Teaches the patient how to care for himself/herself whenever possible.
11. Suggests questions for the patient to ask her/his doctor.
12. Is honest with the patient about his medical condition.

Subscale: Comforts

Items:

13. Provides basic comfort measures, such as appropriate lighting, control of noise, adequate blankets, etc.
14. Provides the patient encouragement by identifying positive elements related to the patient's condition and treatment.
15. Is patient even with "difficult" patients.
16. Is cheerful.
17. Sits down with the patient.
18. Touches the patient when he/she needs comforting.
19. Listens to the patient.
20. Talks to the patient.
21. Involves the patient's family or significant others in their care.

Subscale: Anticipates

Items:

22. Realizes that the nights are frequently the most difficult time for the patient.
23. Anticipates the patient's and her/his family's shock over her/his diagnosis and plans opportunities for them, individually or as a group, to talk about it.
24. Knows when the patient has 'had enough' and acts accordingly, e.g., rearranges an examination, screens visitors, insures privacy.
25. Is perceptive of the patient's needs and plans and acts accordingly, e.g., gives anti-nausea medication when patient is receiving medication which will probably induce nausea.
26. Anticipates that the 'first times' are the hardest and pays special attention to the patient during these times.

Subscale: Trusting Relationship

Items:

27. When with a patient, concentrates only on that one patient.
28. Continues to be interested in the patient even though a crisis or critical phase has passed.
29. Offers reasonable alternatives to the patient, such as choice of appointment times, bath times, etc.
30. Helps the patient establish realistic goals.
31. Checks out with the patient the best time to talk with the patient about changes in his/her condition.
32. Checks her/his perceptions of the patient with the patient before initiating any action, e.g., if she/he (the nurse) has the feeling that the patient is upset with the treatment plan, discusses this with the patient before talking about it to the doctor.
33. Helps the patient clarify his thinking in regard to his/her disease and treatments.
34. Realizes that the patient knows himself the best and whenever possible includes the patient in planning and management of his/her care.
35. Encourages the patient to ask her/him any questions he/she might have.
36. Puts the patient first, no matter what else happens.
37. Is pleasant and friendly to the patient's family and significant others.
38. Allows the patient to express his feelings about his/her disease and treatment fully, and treats the information confidentially.
39. Asks the patient what name he/she prefers to be called.
40. Has a consistent approach with the patient.
41. Gets to know the patient as an individual person.
42. Introduce himself/herself and tells the patient what she/he does.

Subscale: Monitors and Follows Through

Items:

- 43. Is professional in appearance--wears appropriate identifiable clothing and identification.
- 44. Makes sure that professional appointment scheduling e.g., x-ray, special procedures, etc. are realistic to the patient's condition and situation.
- 45. Is well organized.
- 46. Knows how to give shots, I.V.s, etc. and how to manage the equipment like I.V.'s, suction machines etc.
- 47. Is calm.
- 48. Gives good physical care to the patient.
- 49. Makes sure others know how to care for the patient.
- 50. Knows when to call the doctor.

Appendix B

Permission to use Care-Q

School of Nursing
Department of Physiological
Nursing, N 611Y - Box 2510
San Francisco, CA 94143-0510
Fax (415) 476-8899

University of California - San Francisco...A Health Sciences Campus

June 24, 1994

Diane Dahl
1427 Apache Street
Holland, MI 49424

Dear Ms. Dahl:


Thank you for your interest in my work on caring. I am enclosing the information on: 1) the description of the derivation of the CARE-Q I items and scales; and 2) the evolved CARE/SAT as detailed in the attached article.

To use the CARE/SAT, all questionnaires must be xeroxed from the enclosed copy. This is to ensure that the visual analog line remains a constant 100mm line (apparently xeroxing from copies causes the line to be enlarged in length). To gain the patients' response, use a metric ruler and measure at the mid-point of the "X". If the patient makes two "X's," toss a coin to select one. If the patient marks an "X" beyond the line, consider it 100; if below, it is then ranked as 0. The CARE-Q in its present form does not generate a total score.

You are welcome to use either instrument. If you want to change the content or format of either instrument, please be aware that it will be important that the psychometric properties of the changed instrument will need to be addressed. If you decide to use one or both, please let me know and provide me with an abstract of the study's findings upon completion. I would also appreciate your acknowledgement of my authorship of the instrument.

If I can be of further assistance, please let me know.

Sincerely,


Patricia J. Larson, RN, DNSc, FAAN
Associate Professor and Director of the Oncology Program
American Cancer Society Professor in Oncology Nursing
Director, Center for Symptom Management

PL/eh
Enclosures

Appendix C

Consent Form

I understand that this is a study of what I perceive as important nurse caring behaviors.

I also understand that:

1. participation in this study will involve sorting cards into appropriate pockets and take between 45 to 60 minutes.
2. it is not anticipated that this study will lead to physical or emotional risk to myself.
3. the information I give will be kept strictly confidential and the data will be coded so that identification of individual participants will not be possible.
4. a summary of the results will be made available to me upon my request.

I acknowledge that:

"I have been given an opportunity to ask questions regarding this research study, and that these questions have been answered to my satisfaction."

"In giving my consent, I understand that my participation is voluntary and that I may withdraw at any time without affecting the care I receive from my physician or the nursing staff."

"I hereby authorize Diane Dahl to release the information obtained in this study to scientific literature. I understand that I will not be identified by name."

"I acknowledge that I have read and understand the above information, and that I agree to participate in this study."

Witness

(Participant Signature)

Date

(Date)

I am interested in receiving a summary of the study results.

You may contact me at any time: Diane Dahl #616-399-3147 (phone number)

Appendix D

Verbal Script

"Good morning (afternoon or evening). My name is Diane Dahl. I am a nurse working on my master's degree in nursing at Grand Valley State University. I have chosen to study caring, specifically what patients feel are important nursing behaviors that make them feel cared for. If you agree to participate in the study you will be asked to sort cards containing statements about nurse caring behaviors, ranking them from most important to least important. This will require about 45 to 60 minutes of your time. Would you like to participate in this study? (yes/no, thank you very much) Here are written instructions that I will review with you."

Appendix E

Directions

The Caring Assessment Report Evaluation Q-Sort (Care-Q) packet contains seven pockets, each labeled with a number (1, 4, 10, 20, 10, 4, 1). Included in the packet are a deck of 50 cards, each with a different caring nurse behavior typed on it.

To identify the nurse caring behaviors which are perceived as most important, sort the deck of 50 cards from most important to least important, placing each card into one of the pockets -- on a range of most important to least important.

It is essential that only the designated number of cards be placed in each pocket, the numbers (1, 4, 10, 20, etc.) on the pocket indicate the number of cards which can be placed in each pocket. When you have completed the sorting, please count the number of cards in each pocket to make sure the right number of cards is in each pocket. Please sort the cards without assistance.

Please answer the questions on the Patient Demographic Information Sheet.

I will return in 15 minutes to answer any questions and in one hour to pick up the study.

Thank you so much for your help.

Appendix F

code # _____

Patient Demographic Information Sheet

Please check appropriate space for following questions

1. Age (optional)
18 to 35 years _____
36 to 50 years _____
51 to 65 years _____
65 year + _____
2. Sex (optional)
Male _____
Female _____
3. Educational Background
(Please check highest level completed)
Elementary _____
High school _____
College _____
Graduate School _____
4. Work status: Fulltime _____
Parttime _____
Not employed _____
5. Diagnosis _____

Appendix G

EXAMPLE OF TOOL

(CARE-Q item #38)

3" x 5" card

Allows the patient to express his/her feelings about his/her treatment fully, and treats the information confidentially.

0919

for use in computer
program CARE-Q Item
Identification

MOST IMPORTANT

Library Card
Pocket

Appendix H

Comparison of Findings of Patient's Five Most Important
Nurse Caring Behaviors

Item	Dahl 1995 N=37	von Essen 1991 N=105	von Essen 1991 N=43	KCR 1987 N=26	Larson 1984 N=57	Larson 1987 N=57	Mayer 1987 N=54
Knows how to give shots, etc	5.05	5.27	4.91	5.04	5.04	5.04	5.48
Is cheerful							5.42
Encourages patient							4.92
Put patient first		4.85	4.65	5.15			4.90
Anticipates first time hardest							4.85
Responds quickly	5.03				4.61		
Gives good physical care	5.12			4.69	4.60	4.60	
Gives patients tx & meds	5.03			4.81	4.56	4.56	
Is honest with patient		4.99	5.28				
Tells patient in understandable terms		4.85	4.86				
Listens			4.81				
Knows when to call M.D.	5.51	5.31		5.39	4.85	4.84	
Checks on patient						4.35	

LIST OF REFERENCES

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- Brown, L. (1986). The experience of care: Patient perspectives. Topics in Clinical Nursing, 8, 56-62.
- Cronin, S. N., & Harrison, B. (1988). Importance of nurse caring behaviors as perceived by patients after myocardial infarction. Heart & Lung, 17, 374-380.
- Duffy, J. R. (1990). The relationship between nurse caring behaviors and selected outcomes of care in hospitalized medical and/or surgical patients. Unpublished doctoral dissertation, Catholic University of America, Washington, D.C.
- Huggins, K. N., Gandy, W. M., & Kohut, C. D. (1993). Emergency department patients' perception of nurse caring behaviors. Heart & Lung, 22, 356-364.
- Keane, S. M., Chastain, B., & Rudisill, K. (1987). Caring: Nurse-patient perceptions. Rehabilitation Nursing, 12, 182-187.
- Larson, P. J. (1984). Important nurse caring behaviors perceived by patients with cancer. Oncology Nursing Forum, 11, 46-50.
- Larson, P. J. (1986). Cancer nurses' perceptions of caring. Cancer Nursing, 9, 86-91.
- Larson, P. J. (1987). Comparison of cancer patients' and professional nurses' perceptions of important nurse caring behaviors. Heart & Lung, 16, 187-193.
- Larson, P. J., & Ferketich, S. L. (1993). Patients' satisfaction with nurses' caring during hospitalization. Western Journal of Nursing Research, 15, 690-707.
- Mayer, D. K. (1987). Oncology nurses' versus cancer patients' perceptions of nurse caring behaviors: A replication study. Oncology Nursing Forum, 14, 48-52.
- Riemen, D. J. (1986). Noncaring and caring in the clinical setting: Patients' descriptions. Topics in Clinical Nursing, 8, 30-36.

Rosenthal, K. A. (1992). Coronary care patients' and nurses' perceptions of important nurse caring behaviors. Heart & Lung, 21, 536-539.

von Essen, L., & Sjoden, P.-O. (1991). The importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. International Journal of Nursing Studies, 28, 267-281.

von Essen, L., & Sjoden, P.-O. (1991). Patient and staff perception of caring: Review and replication. Journal of Advanced Nursing, 16, 1363-1374.

Watson, J. (1979). Nursing: The philosophy and science of caring. Boston: Little, Brown and Company.

Watson, J. (1988). Nursing: Human science and human care. A theory of nursing. New York: National League for Nursing.