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Caring Behaviors in the Emergency Department: Perceptions of Patients and Nurses

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by

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ABSTRACT

CARING BEHAVIORS IN THE EMERGENCY DEPARTMENT:

PERCEPTIONS OF PATIENTS AND NURSES

by

Marcia Moerman

Caring is recognized as an essential element in the definition of nursing. The purpose of this research study was to identify and compare the perceptions of caring behaviors held by patients in the emergency department with Registered Nurses who practiced in the same department.

Two questionnaires were used to obtain data. The first was an instrument listing 30 caring behaviors. The responses were listed by mean for the patient group and the nurse group. The Mann-Whitney U test was used to test the magnitude of the difference between the two groups. The second was a demographic questionnaire describing characteristics of each group.

The findings did not support the hypothesis that there would be a difference between the two groups. However, there were seven statements with a statistically significant difference in response.

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CHAPTER 1

INTRODUCTION

Caring is an essential element in the definition of nursing. Both the public and professional nurses use the words care and caring to define nursing (Clarke & Wheeler, 1992). Caring can be called a nursing behavior when it describes activities of nursing. Caring has an emotional component when the nurse "cares about" the patient. Being "careful" implies that the nurse is cautious to do a procedure correctly (Barnum, 1994). Semonin-Holleran (1990) described the three constructs of caring as the activities, behaviors, and perceptions of caring.

Problem Statement

If caring is an essential part of nursing, it is critical to understand which behaviors of the nurse are perceived by the patient as caring, and to determine if nurses perceive these same behaviors as caring. When specific behaviors perceived by the patient as caring are identified, nurses can demonstrate caring by using

these behaviors. When caring behaviors are used patients may be more satisfied with their nursing care than if they perceive behaviors to be non-caring. Healthcare institutions depend on satisfied customers to bring return business. "Nurses practice in a patient-driven service industry ... nursing is the key determinant of overall patient satisfaction with hospitalization. Therefore it is necessary to identify and evaluate unique nursing behaviors that advance patient satisfaction" (Greeneich, 1993, p.62).

Congruence between patients' expectations of caring and nursing behaviors will contribute to patient satisfaction because patients expect caring behaviors from nurses. Identification of behaviors perceived by patients as caring behaviors allows the nurse to practice in a manner that communicates caring to the patient.

Nurses, as members of a humanistic profession, value each person as a unique human being. This value is communicated by caring behaviors. It could also be said that non-caring behaviors diminish the human interaction between nurse and patient. Nurses care for and about their patients. One reason for choosing the

nursing profession is respect for self and others, and a desire to help those in need. The motivation for caring comes from the ethical base of nursing practice (Pollack-Latham, 1991). If patient perception of caring behaviors is defined, nurses can use this knowledge to modify their practice to incorporate caring behaviors.

Significance to Nursing

One must be able to define which behaviors patients perceive as caring before those behaviors can affect outcomes: for example, will interventions be effective if they are delivered by a care giver that the patient perceives as uncaring? Identification of behaviors perceived by patients as caring must be done before there can be effective education of nurses about caring behaviors.

Purpose

The purpose of this study is to compare the perceptions of caring behaviors held by patients in the emergency department with those held by registered nurses practicing in the emergency department.

CHAPTER 2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Conceptual Framework

Jean Watson's theory of human caring will provide the theoretical basis for this study. Watson defined nursing as caring, using the term carative to differentiate nursing from medicine which is concerned with curing (Watson, 1979). Caring is the moral ideal of nursing in Watson's theory (Watson, 1985). Without caring there is no nursing.

Carative Factors

The carative factors are the framework for the caring occasion which involves both the nurse and the patient in choosing and acting. Both the nurse and the patient are engaged fully in the relationship, affected by the transpersonal dimension of nursing (Watson, 1990). Caring as the moral ideal of nursing moves the nurse toward action. The carative factors become the nursing interventions in the nurse-patient relationship (Watson, 1985). Watson believes that caring promotes

health and human growth, satisfies human need, and compliments the science of curing. Caring is central to health and healing in Watson's view and curing is secondary (Watson, 1990).

The carative factors are the structure for understanding nursing as caring. The carative factors are (a) formation of a humanistic-altruistic system of values, (b) instillation of faith-hope, (c) cultivation of sensitivity to one's self and to others, (d) development of a helping-trusting relationship, (e) promotion and acceptance of the expression of positive and negative feelings, (f) systematic use of the scientific problem-solving method for decision making, (g) promotion of interpersonal teaching-learning, (h) provision for a supportive, protective, and (or) corrective mental, physical, sociocultural, and spiritual environment, (i) assistance with the gratification of human needs, (j) allowance for the existential-phenomenological forces (Watson, 1979, p.9-10).

Major Concepts

Watson's theory of human caring can be related to the four major concepts of person, health, environment,

and nursing (Talento, 1990). Watson (1985) views a human being as:

> ... a valued person ... to be cared for, respected, nurtured, understood and assisted; in general a philosophical view of a person as a fully functional integrated self. The human is viewed as greater than, and different from, the sum of his or her parts. (p. 14)

For Watson the uniqueness of each person is affected by their causal past. Watson defined causal past as the unique collection of experiences and events that each person brings to the present moment (Watson, 1985).

Health is defined by Watson (1979) as "a process of adapting, coping, and growing that goes on from conception to death" (p. 219). Later she described health as harmony between body, mind, and soul which results in congruence between perception of self and experience of self (Watson, 1985).

Watson (1979) recognized the effects of environment. She realized that life-style, behavior and personality and social environment all affect the health of an individual. Watson viewed the patient as part of a social network which contributes to his or

her health.

Nursing is described by Watson (1985) as "a human science of persons and human health-illness experiences that are mediated by professional, personal, scientific, aesthetic, and ethical human care transactions" (p. 54). Nursing is a caring relationship between the nurse and patient that involves all aspects of both the nurse and the patient. Nursing's goal is to promote a higher degree of harmony which will generate self-knowledge, reverence, healing, and caring while allowing for greater diversity (Watson, 1985).

Other Concepts

For Watson (1985) there are other concepts which are as important as the four major concepts. These include human need, the phenomenal field, and the caring occasion. These concepts help define the nurse/patient relationship.

Nursing as caring recognizes and responds to human need. Human need is a motivating force for relationships in Watson's (1985) theory:

> Human needs consist of the need to be loved and cared for and about, the need for positive regard

and the need to be accepted, understood, and valued. There is also a human need to achieve union, transcend one's individual life, and find harmony with life. (p.57)

The phenomenal field is the sum of human experience. It is the frame of reference for the individual based on the totality of his experiences in the world. It is the subjective reality for the person. The perceptions of the person are formed in the phenomenal field (subjective reality) and not just in the objective reality of the external world (Watson, 1985).

The caring occasion for Watson (1985) happens when the patient and the nurse interact. Both are affected by the interaction. Unlike some traditional visions of nursing where the nurse maintains an emotional distance from the patient, in Watson's view both the nurse and the patient are open to each other, and bring the total reality of body, spirit, and mind to the caring occasion. The result of the interaction is growth for the nurse and the patient.

Use of the Concepts in this Study

Using Watson's (1985) theory as the conceptual

framework for this study of perceptions of caring behaviors, the caring occasion is the interaction between the patient in the emergency department and the registered nurse practicing in the emergency department. This event involves the patient and the nurse with each bringing his or her own causal past and phenomenal field to the interaction. Both the patient's and the nurse's perceptions of caring behaviors will be rooted in his or her own experiences.

The caring occasion begins when the patient is admitted to the emergency department. The relationship between nurse and patient will involve aspects of body, mind and spirit of each person. The basis for the interaction will be the human needs of the patient and the nurse. Caring behaviors develop out of the recognition of the common humanity of the patient and nurse, and the recognition that the patient has needs to be met by the nurse.

For the purpose of this study person will be conceptualized as both the registered nurse practicing in the emergency department and the non-critical patient in the emergency department. Health will be conceptualized as a state of harmony of mind, body, and

spirit. The environment in which this occurs is the emergency department in a small teaching hospital. Nursing will be defined in this study as the behaviors of the nurse that are perceived as caring by the patient.

Literature Review

The review of the literature will initially focus on caring behavior studies conducted in the areas of oncology, rehabilitation, coronary care and medical surgical nursing. This will be followed by a review of research conducted in the area of caring behaviors in the emergency department.

Early research on perceptions of caring behaviors was done with oncology patients and nurses (Larson, 1986, 1987). Researchers used the tools developed in early work to study the perceptions of other patient populations (Keane, Chastain & Rudisill, 1987; vonEssen & Sojden, 1991; Rosenthal, 1992). Larson and Ferketich (1993) replicated Larson's earlier work to modify her instrument. Recently nurse researchers have studied the perceptions of caring behaviors of patients in emergency departments (Huggins, Gandy & Kohut, 1993; Semonin-Holleran, 1990). Although it is not possible

to generalize from any of these studies, taken together there is a growing body of research from a variety of settings and several different types of patients and staff.

Research with Oncology Patients

Larson (1986) conducted a study with hospitalized oncology patients using a forced choice format to determine their perceptions of nurse caring behaviors. The Caring Assessment Instrument (Care-Q) was employed in a two phase study. The first phase looked at identification of nurse caring behaviors as seen by patients and nurses, and the second phase developed those behaviors into a reliable instrument.

In Phase I of Larson's (1986) research, two studies were done with nurses who defined the components of caring in nursing and with patients who defined their perceptions of the nurse's caring behaviors. Phase II involved two studies that reviewed the specific responses from Phase I to verify content validity and remove redundancy. In Phase II the Care-Q instrument was refined.

Larson's (1986) research involved 57 practicing nurses in three hospitals in the Northwest. The nurses

identified listening to the patient and other affective behaviors of answering call lights promptly, putting the patient first, and giving physical care, as being the most important caring behaviors. Larson (1987) used the same instrument with 57 hospitalized oncology patients who identified monitoring, follow-through, and accessibility as most important.

There are several limitations to Larson's (1986, 1987) studies. The format of the instrument forced the choice of one behavior as most important, and only the behaviors listed on the instrument could be chosen. Larson questioned whether the nurses ranked items as they thought they should rather than as they actually practiced. The results would be skewed if the nurses attempted to choose "correct" responses. The sample was restricted to hospitalized oncology patients and nurses who practiced on oncology units in the hospital. This limits the ability to generalize the results.

Research with Rehabilitation Patients

Keane, Chastain and Rudisill (1987) replicated Larson's (1986) work with a sample of rehabilitation patients. Using Larson's instrument, data were collected from 26 registered nurses and 26 hospitalized

rehabilitation patients. Perceptions of important nurse caring behaviors were obtained by sorting cards which listed behaviors into seven packets ranging from most important to not important.

Patients and nurses identified the most important behavior as "knows when to call the doctor." Patients in this study (Keane, Chastain & Rudisill, 1987) identified monitoring, follow-though, and accessibility as important caring behaviors. Nurses ranked self-care practices and active participation by patients as important caring behaviors. This study supported Larson's (1986) finding that hospitalized patients considered supportive affective behaviors less important than expert physical care.

One limitation of this study (Keane, Chastain & Rudisill, 1987) is related to the format of the instrument which forced the choice of one behavior as most important. The choices were limited to the 50 behaviors in the instrument. Nurses may have considered some behaviors as givens, and didn't consider those as behaviors that indicate caring. Another limitation was the small sample size (N= 26).

Research with Coronary Care Patients

Rosenthal (1992) replicated Larson's (1986) research with 30 coronary care patients and nurses who practiced in the Coronary Care Units of three hospitals. The results supported Larson's finding that nurses and patients disagreed on which behaviors demonstrate caring. Nurses chose expressive care as most important while patients chose knowing how to do procedures and manage equipment as most important.

The limitations of Rosenthal's (1992) study relate to the instrument and the sample. The Care-Q instrument forced the choice of one behavior out of the 50 listed as most important. The forced choice format frustrated both the nurses and patients by restricting their responses. The sample was small (N= 30) and only hospitalized cardiac patients and nurses who practiced in this specialty were included.

Research with Medical Surgical Patients

In their work, vonEssen and Sjoden (1991) modified the methodology of previous research. They used the Care-Q instrument with one group and a questionnaire based on the same 50 behaviors with another group. Eighty-six patients from units representing a variety of medical and surgical subspecialities and 76 nurses

and unlicensed care givers from the same units participated in the study. Subjects were randomly assigned to use the Care-Q instrument or the questionnaire.

Patients using the Care-Q and patients using the questionnaire ranked " honest and clear information" and "clinical competency" as most important. Nurses and unlicensed care givers rated expressive/affective behaviors as most important regardless of which instrument they used. The results from vonEssen and Sjoden (1991) supported the findings of Larson (1986) that patients and nurses disagree about behaviors that demonstrate caring.

The limitations of this study (vonEssen & Sjoden, 1991) relate to the forced choice format of the Care-Q instrument. This format only allows one behavior to be chosen as most important and the number of behaviors to chose are limited to the 50 listed in the instrument.

The researchers (vonEssen & Sjoden, 1991) were able to compare results obtained using the Care-Q with those obtained by using the questionnaire. Using two instruments allowed the researchers to compare results from four samples rather than two. Use of patients

from various subspecialites in medical and surgical nursing increased the ability to generalize the results. Non-licensed assistive personnel as well as nurses participated in this research which increased the variety in the sample. Nurses, by virtue of their education, may make certain assumptions that influence the choices they make. For example, nurses may assume that technical skill is a given and may not recognize this as an indication of caring. Non-licensed personnel may make assumptions based on experience working with nurses and patients, but have different educational preparation than nurses. The sample was larger (N=162) than the studies previously cited. This increased the ability to generalize the results.

Larson and Ferketich (1993) continued Larson's earlier (1986) research on caring. The Care-Q instrument was modified to measure patient satisfaction as well as perceptions of caring behaviors and was named the Care/Sat questionnaire. The results would measure whether or not patients experienced the behaviors which had been identified as caring. Using this instrument, Larson and Ferketich measured the responses of 286 hospitalized adult medical-surgical

patients in four hospitals. Hospitals A and C were research/teaching hospitals, hospital B was a research/catastrophic illness hospital, and hospital D was a community hospital. Individual items on the questionnaire were ranked from strongly agree to strongly disagree, indicating that patients had or had not experienced a particular nursing action or attitude during their hospital stay.

Mean scores of the Care/Sat questionnaire were skewed positively; patients felt they had experienced nurse caring behaviors. The ANOVA was statistically significant for caring behaviors ($p < .05$). The Tukey B was used as the post-hoc test. It indicated that patients in Hospital D were more satisfied with their care than were patients from Hospitals A, B, or C (Larson & Ferketich, 1993).

Some of the limitations of earlier research (Larson, 1986) using the Care-Q instrument were addressed by changing the format of the instrument. Patients were not forced to choose one behavior as most important in their perception of caring by the nurse, but rather could rank each behavior described in the questionnaire. However, the patients were able to rank

only the behaviors that the researcher included in the instrument. The sample in the study was large (N=286) and from a variety of medical-surgical settings which increased the ability to generalize the results.

Research with Emergency Department Patients

Huggins, Gandy, and Kohut (1993) identified those nurse behaviors that were perceived as caring behaviors by a group of emergency department patients. In this study, 288 patients were surveyed by telephone interview within 30 days of discharge from the emergency department. Questions for the interview were taken from the Caring Behaviors Assessment tool. The sample was selected from the populations served by two emergency rooms in private, urban hospitals. The researchers found that patients identified technical nursing behaviors as " most important" in their perception of caring. These technical behaviors included giving injections, starting intravenous lines, handling equipment, performing tests, responding to an emergency situation, checking the patient's condition, and knowing when to call the doctor.

The limitations of the study (Huggins, Gandy, & Kohut, 1993) were that patients who did not have

telephones were excluded from the study. A time delay between discharge and interview could alter perceptions of care. Some of the calls were made up to 30 days after discharge. Both emergency department patients and family members were interviewed, but there was no attempt to verify if family members were accurate in their descriptions of what patients perceived. These factors make it difficult to generalize the results of the study.

Semonin-Holleran (1990) recognized that patients in the emergency department were different than other groups of patients that had been used in studies of caring behavior. The myriad of problems, the range of age, the levels of acuity from life-threatening illness or injury to simple suture removals that are the daily scope of practice in the emergency department makes this area different than any other patient care area. Therefore, research on perceptions of caring with patients in the emergency department would add to the body of knowledge about caring.

The purpose of the study was "to develop an instrument that described from the patient's perspective the activities, behaviors and meaning of

caring by nurses in the emergency department" (Semomin-Holleran 1990, p. 3). Semonin-Holleran used a methodological research design. The intent of methodological research is to address the development, validation, and evaluation of research tools (Polit & Hungler, 1991). An instrument was developed to measure the activities, behaviors, and experience of caring from the perspective of patients treated in the emergency department. A questionnaire consisting of 30 statements was given to patients in the emergency department of a large Midwestern teaching hospital. The responses were analyzed to describe how patients perceived caring activities and behaviors, and to measure the experience (perception) of caring by patients in the emergency department.

The sample for Semonin-Holleran's (1990) study was 161 patients in the emergency department. Criteria for inclusion in the study were (a) ability to complete a written instrument, (b) age of eighteen or over, (c) willingness to participate in the study, and (d) length of stay in the patient care area for a minimum of one hour. Patients who were admitted to the hospital, as well as those who were treated in the emergency

department and released, were included, but patients with a possible life-threatening illnesses were not asked to participate.

The results of Semonin-Holleran's (1990) research revealed that subjects agreed that the items on the instrument indicated caring behaviors, activities, and experiences from the patient's perspective. However, factor analysis did not support the theoretical constructs since all the factors loaded under the first factor which was named "Caring". The strengths of the study include that it provided a description of caring activities, caring behaviors, and caring experiences from the patient's perspective, and an instrument was developed that can identify these activities, behaviors, and experiences. Behaviors, activities and experiences patients considered as non-caring were identified and also loaded under the first factor. These include the nurse not being honest with the patient, not recognizing that the patient was in pain or uncomfortable, not answering questions, not listening to the patient, and not being patient with difficult patients.

Limitations of the study (Semonin-Holleran,

1990) relate to the setting. The instrument was used in one emergency department setting. The emergency department was located in a large teaching hospital in an urban setting. The results may be different in a small rural hospital, or a non-teaching hospital.

Semonin-Holleran (1990) concluded that the instrument should be used for further study of caring behaviors, activities, and perceptions in the emergency department. Using the same instrument in different emergency department settings will add to the growing body of knowledge describing what patients' identify as caring.

Summary of Literature Review.

This review of the literature suggests a gap between patients' perceptions of caring behaviors and nurses' perceptions of caring behaviors. Early research compared the perceptions of oncology and cardiology patients and nurses who practiced in these settings. Later research was done to refine instruments and involved patients from a variety of medical-surgical arenas. Recently there have been two studies involving the perceptions of caring behaviors of emergency department patients. The body of knowledge

about patients' and nurses' perceptions of caring behaviors was increased with each new sample studied and each new setting used.

Research Question

What are the perceptions of caring behaviors held by patients in the emergency department and registered nurses practicing in the same emergency department?

Research Hypothesis

There will be a difference between the perceptions of caring behaviors held by patients in the emergency department and those held by registered nurses who practice in the same emergency department.

CHAPTER 3

METHODOLOGY

Research Design

A descriptive comparative design was used to study the perceptions of caring behaviors held by patients in the emergency department and those held by registered nurses who practice in the emergency department. The purpose of a descriptive study is to observe, describe, and document a situation (Polit & Hungler, 1991). There was no manipulation of an independent variable or random assignment to groups.

Instrument

The instrument used to measure patient perceptions of caring behaviors and nurse perceptions of caring behaviors was developed by Semonin-Holleran (1990), and was used with permission (see Appendix A). The instrument consisted of 30 statements which were followed by a Likert-type rating scale which asked the subject to rate the statement as strongly disagree, disagree, agree, or strongly agree. The instrument was

developed to define the activities, behaviors and the experience of nursing. Factor analysis was done by Semonin-Holleran which indicated that all of the factors loaded under the factor named CARING, and the instrument did not delineate the phenomenon of caring into the constructs of activities, behaviors, and the perception of caring. The Semonin-Holleran instrument was reviewed by practicing emergency room nurses for face validity, and piloted with a volunteer sample of 71 registered nurses to establish content validity. The Cronbach's alpha computed for the instrument was 0.90, indicating a high degree of internal consistency. In this study the Cronbach's alpha for the instrument was 0.95.

The instrument developed by Semonin-Holleran (1990) was chosen for this study because it relates to Watson's (1979) carative factors. The relationship between the carative factors and the questionnaire is demonstrated by listing the carative factors and the statements from the questionnaire that fit under each factor in Table 1.

Two separate questionnaires were used in the study to determine sample characteristics. Data on age, sex,

Table 1
Relationship between Watson's Carative Factors and the Caring Instrument

Watson's Carative Factors	Caring Instrument Item	Caring Instrument Content
Humanistic-Altruistic values	2	touching me
	3	providing comfort
	15	being patient with me
	21	looking at me
	29	being honest
	30	doing what I asked/explaining
Faith/Hope	9	giving encouragement
Sensitivity to self and others	4	seeing I was uncomfortable
	5	listening
	6	knowing what I needed
	7	knowing I was afraid
	10	crying with me
	14	seeing I need help
	16	recognise I have pain
	19	recognise I was hurting
	28	trying to understand
Helping/Trusting relationship	7	knowing I was afraid
	14	seeing that I need help
	23	recognizing who the nurse was
	27	making a phone call
Promotion/Acceptance of feelings	5	listening to what I said
	6	knowing what I needed
	10	crying with me
	11	being patient with difficult patients
	28	trying to understand how I'm feeling
Scientific problem solving	17	knowing how to give a shot
	18	working with the physician
	26	being able to start my IV
Interpersonal Teaching/Learning	1	answering questions
	11	explaining what was being done
	24	providing information

Note: Items are not mutually exclusive for Watson's carative factors

Table 1 (cont)

Relationship between Watson's Carative Factors and the Caring Instrument

Watson's Carative Factors	Caring Instrument Item	Caring Instrument Content
Supportive/Protective/ Corrective Environment	8	closing curtain
	12	getting family
	13	standing by my bed
	25	not leaving me alone
	28	trying to understand how I'm feeling
Gratification of human needs	2	touching me
	3	providing comfort
	5	listening to me
	20	addressing me appropriately
	21	looking at me while talking to me
	24	providing information
	25	not leaving me alone
	29	being honest
Existential/ Phenomenological forces	4	seeing I was uncomfortable
	6	knowing what I needed
	7	knowing that I was afraid
	14	seeing that I need help
	16	recognise that I am in pain
	28	trying to understand how I am feeling

marital status, and ethnic background were obtained from both patients and registered nurses. Educational information was sought from both patients and nurses. Patients were asked about years of education and nurses were asked about their educational preparation for nursing. In addition, nurses were asked about the number of years of practice in emergency nursing (see Appendix B).

Procedure

During the time of data collection the researcher obtained a list of patients who were registered in the emergency department in the preceding hour. For example at 0800 the list of patients who registered from 0600 to 0700 was obtained. This list was compared with the assignment board that showed which patients were assigned to each room. Patients from the list who had been evaluated and assigned to the rooms in the less acute area were approached and an explanation of the study was given with the consent (see Appendix C). The patient was then given the opportunity to ask questions. When all questions had been answered, permission was sought for inclusion in this study. The patient signed a consent form indicating consent to

participate in the study. The "Caring in the Emergency Department" instrument and the "patient characteristic questionnaire" was given to the patient. The investigator returned following 15 minutes of elapsed time to collect the completed instruments. This process was repeated until 40 patients agreed to participate in the study.

Registered nurses were approached in the following manner. First the investigator attended staff meetings for all three shifts to introduce the study to the nursing staff and to answer any questions that might be asked. Questionnaires were then placed in the mailboxes of all registered nurses who practice in the emergency department. Included in the envelope with both questionnaires was a cover letter that explained the purpose of the study (see Appendix D). Consent to participate in the study was implied by return of the completed questionnaires. A box labeled "Caring Behaviors Research" was placed in the staff lounge. An envelope for the completed questionnaires was provided in the packet. The nurses were asked return all questionnaires in the box whether completed or not to protect the anonymity of those participating.

One week after the questionnaires were placed in the mailboxes of Registered Nurses, a reminder poster was hung in the staff lounge encouraging those who had not completed the questionnaire to do so. At the end of three weeks it was assumed that all nurses who intended to return the questionnaires had done so. Thirty seven questionnaires were placed in mailboxes labeled with the names of Registered Nurses. Twenty three completed questionnaires and one blank questionnaire were returned.

Approval Process

Approval to conduct this research was obtained from the Human Research Review Committees of Grand Valley State University and Bronson Methodist Hospital (see Appendix E).

Setting and Sample

The setting of this study was the emergency department in a community teaching hospital in the Midwest. The census of this emergency department is approximately 60,000 patient visits per year. The populations served are pediatric, adolescent, adult, and geriatric with a variety of injuries and medical, surgical, and psychiatric illnesses. Patients eligible

for inclusion in the study were those who had been assessed as having non-critical illnesses or injuries, and therefore had been assigned to rooms in the less acute area. The subjects were able to read and write in English, and were age 18 or older. Patients who were unable to fill out the questionnaire, or who were discharged from the department in less than 1 hour were excluded from the study. All registered nurses who were practicing in the emergency department at the time of this study were eligible for inclusion in this study.

The actual patient sample and nurse sample characteristics are described in Table 2. Educational preparation of patients, nurses' educational preparation, and years of nursing practice will be shown in Table 3.

Table 2

Characteristics of Patient and Nurse Sample

Characteristics	Patient n	Nurse n	Total n	(%)
Sex:				
Male	11	4	15	(25.4%)
Female	25	19	44	(74.5%)
Marital Status:				
Never Married	13	2	15	(25.4%)
Married	15	15	30	(50.8%)
Divorced/Separated	8	6	14	(23.7%)
Ethnic Background				
African-American	7	1	8	(13.8%)
Caucasian	22	21	43	(74.1%)
Hispanic	3		3	(5.2%)
Other	3	1	4	(6.9%)

Age:	Patient	Nurse	Total
	n=36	n=23	n=59
Range	18-74	28-46	
Mean	34.944	36.783	
SD	12.492	4.991	

Note: One patient did not answer the question regarding ethnic background

Table 3

Education of Patients and Nurses and Nurses' Years of Practice

Patients' Education	n	Nurses' Education	n
9th-12th	9	Diploma	7
HS grad	14	AD	11
2yr/ AD	6	BS/BA	1
4yr/BA	2	BSN	4
Master's	1		
other	4		

Nurses' Years of Practice

Range	1-18
Mean	7.565
SD	4.998

CHAPTER 4

RESULTS

The purpose of this research was to (a) identify the perceptions of caring behaviors held by patients in the emergency department, (b) identify perceptions of caring behaviors held by nurses in the emergency department, and (c) compare the perceptions of the two groups. Data analysis was accomplished utilizing the Statistical Package for Social Sciences (SPSS/PC+) software.

Research Question

The research question in this study was: What are the perceptions of caring behaviors held by emergency department patients and registered nurses who practice in the same department. The Caring in the Emergency Department Questionnaire consisted of 30 statements. After each statement the subject circled the response which most closely described his/her feelings about each sentence. The responses were SD (Strongly Disagree), D (Disagree), A (Agree), and SA (Strongly Agree). For statistical analysis numbers were substituted for the responses with SD=1, D=2,

A=3, and SA=4. The listing from high to low of statements about caring behaviors identified by patients (see Appendix F) and nurses (see Appendix G) was determined by the mean.

Hypothesis

The research hypothesis for this study was: There will be a difference between the perceptions of caring behaviors held by patients in the emergency department and those held by registered nurses who practice in the same emergency department. The Mann-Whitney U test was used to test the magnitude of the difference between the response of patients and nurses. Significance was set at $p=<.05$ for all tests.

Data analysis included a comparison of the listing of caring behaviors as selected by emergency department patients and nurses. The listing of statements about caring behaviors identified by patients (see Appendix F) and nurses (see Appendix G) was determined by the mean score. Table 4 depicts the 10 statements most strongly agreed with by patients.

Analysis of the data reveals that no patient strongly disagreed with any of the top 10 statements. Of the top 10 statements, two patients (5.6%) marked "disagree" for the statement "the nurse being honest with me demonstrates caring to me". On the other 9 statements only

Table 4

Caring Statements Most Strongly Agreed with by Patients

Statements Chosen by Patients	Item Number on Questionnaire	Mean
1. Providing comfort	# 3	3.611
2. Answering questions	# 1	3.500
2. Seeing I was uncomfortable/ asking what's wrong	# 4	3.500
4. Getting family	# 12	3.472
5. Understanding what I'm feeling	# 28	3.444
5. Being honest	# 29	3.444
7. Giving encouragement	# 9	3.417
8. Explaining what was being done	# 11	3.389
8. Being patient with difficult patients	# 15	3.389
10. Listening to what I said	# 5	3.361

one patient (2.8%) marked the choice "disagree".

The ranking of statements most strongly agreed with by nurses is found in Table 5. None of the nurses strongly disagreed with any of the top 11 statements, but the percentage who disagreed with one or more of the top 11 statements ranged from 8.7% to 17.4%

Both patients and nurses ranked providing comfort as the most important caring behavior. Seven of the statements are the same, although in different order, except patients chose "being honest", "answering questions", and "seeing that I was uncomfortable and asking what's wrong" as one of the top ten statements while nurses picked "knowing what I needed without being asked", "knowing that I was afraid", and "recognizing that I'm in pain".

The ten least agreed with statements about caring behaviors that patients chose are listed in Table 6. Listed first is the most strongly disagreed with statement and the last is the least strongly disagreed with of the ten. Table 7 lists those statements chosen by nurses as the ones with which they least agreed.

Using the rank ordering of the statements, the magnitude of the difference between the two groups (patients and nurses) was anlyzed using the Mann-Whitney U test.

Table 5

Caring Statements Most Strongly Agreed with by Nurses

Statements Chosen by Nurses	Item Number on Questionnaire	Mean
1. Providing comfort	# 3	3.609
2. Seeing I was uncomfortable/ asking what's wrong	# 4	3.435
3. Explaining what's being done	# 11	3.348
4. Listening to what I said	# 5	3.304
4. Knowing what I needed without being asked	# 6	3.304
4. Giving encouragement	# 9	3.304
7. Understanding what I'm feeling	# 28	3.261
8. Knowing I was afraid	# 7	3.217
8. Getting family	# 12	3.217
8. Being patient with difficult patients	# 15	3.217
8. Recognizing that I'm in pain	# 16	3.217

Note: There were 4 responses with a mean of 3.217 which results in 11 statements.

There were seven statements in which there was a significant difference ($p<0.05$) between the responses of patients and nurses as shown in Table 8.

The groups were unequal with 36 in the patient group and 23 in the nurse group. The mean was substituted for missing values (three responses on the Caring Behaviors Questionnaire in the patient group). Even though there were differences in the ranking of the statements, there was not a significant difference between the two groups in the perception of caring behaviors ($p=0.89$). Thus the research hypothesis was rejected.

Table 6

Caring Statement Least Strongly Agreed with by Patients

Statements chosen by Patients	Item number on Questionnaire	Mean
1. Letting me cry	# 22	2.944
2. Not leaving me alone	# 25	3.000
3. Crying with me	# 10	3.028
4. Closing the curtains	# 8	3.056
4. Being able to recognize who the nurse is	# 23	3.056
6. Nurse working with physician to help me	# 18	3.139
7. Nurse standing by my bed	# 13	3.167
8. Addressing me appropriately	# 20	3.194
8. Being able to start my IV	# 26	3.194
10 Recognizing that I'm in pain	# 16	3.222

Note: Patients agreed that all statements except "letting me cry" showed caring with a mean score 3.00 or greater.

Table 7

Caring Statements Least Strongly Agreed with by Nurses

Statement chosen by Nurses	Item Number on Questionnaire	Mean
1. Being able to start my IV	# 26	2.261
2. Being able to recognize who the nurse is	# 23	2.478
3. Knowing how to give a shot	# 17	2.522
4. Nurse standing by my bed	# 13	2.609
5. Nurse working with physician to help me	# 18	2.739
6. Addressing me appropriately	# 20	3.000
6. Not leaving me alone	# 25	3.000
8. Letting me cry	# 22	3.043
9. Closing the curtain	# 8	3.087
9. Providing me with information	# 24	3.087
9. Being honest	# 29	3.087

Note: There were 3 responses with a mean of 3.087 which results in 11 statements. Nurses disagreed with 5 statements (mean <3.000) as caring behaviors.

Table 8

Comparison Demonstrating Relationship of Caring Behaviors Chosen by Patients and Nurses

Statement	Mean Rank Patients	Mean Rank Nurses	U	Z	2-tailed p=
Able to start IV	36.79	19.37	169.5	-4.0004	.0001
Knowing how to give shot	35.40	21.54	219.5	-3.1952	.0014
Able to recognize nurse	34.57	22.85	249.5	-2.7800	.0054
Standing by bed	34.33	23.22	258.0	-2.5841	.0098
Answering questions	33.54	24.46	286.5	-2.2261	.0260
Being honest	33.28	24.87	296.0	-2.0338	.0420
Working with physician to help me	33.06	25.22	304.0	-1.9380	.0526

CHAPTER 5

DISCUSSION AND IMPLICATIONS

The findings of this study did not support the research hypothesis that there would be a difference between the perceptions of caring behaviors held by emergency room patients and those held by emergency room nurses. There were, however, seven statements which will be discussed further that had a statistically significant ($p < 0.05$) difference between the responses of patients and nurses (see Table 8).

Data analysis of the seven statements revealed that a higher percentage of patients than nurses agreed or strongly agreed with these seven statements. In none of the statements does a higher percentage of nurses agree or strongly agree with the statement. Two types of behaviors are described as caring behaviors in these seven statements. Two statements describe the technical behaviors of starting IV's and giving shots. Four of the statements involve interpersonal behaviors of being able to identify who is the nurse, the nurse standing by the bed, answering questions, and being

honest. One statement (the nurse working with the physician to help me) could describe either technical or interpersonal activities. Some of the written comments of nurses and patients provided insight into the different responses. Several nurses indicated that they felt it was an expectation that they be technically competent. It was in the "extra's" that they demonstrated caring. One wrote " some of these descriptions are part of your job....It's just done". Another indicated that it isn't the technical skill in starting IV's or giving shots, but rather the explanations given for the treatments that show caring. Patients did not comment on technical skills directly. One patient described caring behavior as "cares if you are nervous about needles-helps you get through it with humor". Even when describing a technical skill this patient was more interested in the nurse's ability to interact with him than his/her skill in starting the IV or giving the injection.

However the responses to the two statements about technical skills indicates that patients do consider technical skills an indication of caring. A total of 80.6% of patients either agreed or strongly agreed that

the nurse being able to start an IV shows caring. In contrast, only 30.4% of nurses agreed or strongly agreed with this statement. When the skill is giving a shot, 86.1% of patients agreed or strongly agreed that this showed caring. The percentage of nurses who agreed or strongly agreed with this statement was 43.5%.

Patients also indicated that being able to recognize who is the nurse demonstrates caring (86.6% of patients agreed or strongly agreed), while 52.1% of nurses agreed or strongly agreed that this indicated caring. This is important in the emergency room setting were the average stay is measured in hours rather than days. In areas where patients are cared for by the same nurses day after day, recognition of the nurse develops over time. In the emergency room setting where relationships may be minutes or hours long, recognition of the nurse must happen quickly. One patient commented on the professionalism of the nurse and also mentioned the patient care assistant. This patient recognized the difference between the two.

Availability of the nurse is also an area of disagreement between patients' and nurses' perceptions.

Less than half of the nurses (47.8%) agreed or strongly agreed that the nurse standing by the bed showed caring, while 83.3% of patients agreed or strongly agreed with this statement. Some of the written comments also verify this. One patient described caring as the nurse "taking time when she was too busy and frustrated". Another mentioned "careful attention" as caring. This may support the advanced nursing intervention of "presence" as a caring behavior.

Answering questions and being honest are also important to patients as an indication of caring. One patient (2.8%) disagreed that answering questions showed caring and 97.2% agreed or strongly agreed. Being honest was important also (94.4% agreed or strongly agreed). Three nurses (13.0%) disagreed with this statement and 87.0% agreed or strongly agreed. Being honest showed caring to 82.6 % of nurses who agreed or strongly agreed with this statement. Nurses indicated in their written response that giving information and answering questions was an expectation they had of themselves. The nurses felt that caring behaviors were "above and beyond what is expected".

Finally there was a difference between nurses and

patients in their response the statement about the nurse working with the physician. Patients (91.7%) agreed or strongly agreed that this indicated caring. More than half of the nurses (65.2%) agreed or strongly agreed with this statement. Even though there was a statistical difference between the two groups ($p < .0526$), both groups indicated that collaboration and team work between nurses and physicians is caring.

Relationship of Findings to Conceptual Framework

Watson believes that nursing is caring. Caring is the moral ideal for Watson, and without caring there can be no nursing (Watson, 1985). Nursing is a human process where the caring relationship between the nurse and the patient is highly valued (Sourial, 1996.)

Watson's (1985) theory includes the carative factors which presuppose a knowledge base and clinical competence; a commitment toward protecting, enhancing, and preserving human dignity; and affirmation of the subjective significance of the patient. The caring occasion is the moment in which the patient and the nurse actually come together. Both the nurse and the patient bring their own subjective realities to the moment and both can touch the other. In this

relationship caring occurs between the nurse and the patient. The result of the interaction between patient and nurse is healing and harmony (Cereal, 1996).

Watson's (1979, 1985) theory provides a framework for development of nursing interventions where caring behaviors are used in the nurse-patient relationship. These behaviors will demonstrate the nurse's caring to the patient and allow the patient to respond to the nurse. Both the nurse and the patient bring to the caring occasion all of their own subjective reality. Therefore, if there is congruence between the perceptions of caring of the patient and the nurse, the outcome of the caring occasion may be harmony, transcendence, and healing. The measurement of these outcomes is difficult in the emergency department. Often the healing process only begins in the short time the patient is in the emergency department. It is left to the patient and others to see the process to completion.

The difficulty in applying Watson's (1985, 1979) theory to nursing in the emergency department relates to the brevity of the interaction between patient and nurse. The understandings, interactions, and

interventions must occur very quickly. There often is no time to explore feelings, determine meanings, or understand perceptions. However, the research findings do suggest agreement between this group of patients and nurses about caring behaviors, and caring relationships can be built upon mutual understanding of what is caring behavior. Caring behaviors can occur from the initial interaction. Caring can be indicated by competency in nursing actions, and by all the interpersonal interactions which occur during the patient's stay in the emergency department. Therefore the research findings support the application of Watson's (1985) theory to nursing in the emergency department.

Relationship of Findings to Previous Research

In Semonin-Holleran's (1990) research with this instrument, patients' perceptions of caring behaviors were not compared with nurses' perceptions. Where nurses and patients were compared, research with other populations indicated disagreement between nurses and patients about caring behaviors. In the earlier research, patients tended to rank procedural competence higher, and nurses ranked affective behaviors higher.

Technical skill was rated higher by patients in this study in the two questions that specifically addressed it.

Limitations

The findings in this study are from a small, non-random sample (patients: n=36; nurses: n=23) from a single emergency department, therefore the findings cannot be generalized beyond the present sample. A larger sample, random sampling, and multiple settings would improve generalizibilty.

Another limitation was that only non-critically ill or injured patients were selected to participate. Critically ill patients may value different behaviors than non-critically ill patients. Technical skill may be even more important to critically ill patients, and the value of communication and affective behaviors may change with severity of illness.

The use of a specific list of statements may have constrained the variety of responses. Qualitative research with interviews and/or open ended questions may reveal behaviors which indicate caring that were not included in the instrument. Several statements in the questionnaire (numbers 6, 7, 16, 17, 19, and 23)

describe knowledge rather than behaviors. A questionnaire that more clearly distinguished between skills, behaviors, knowledge and attitudes may result in a different identification of caring behaviors.

Approaching patients to participate while they were still patients in the emergency department may have affected the results. Patients may have been concerned that their care would be affected by the responses they gave. Contacting patients after discharge from the emergency room may result in different findings.

Nurses may have responded to the statements from a variety of perspectives. They may have answered as they believed patients might respond, they may have answered as they would feel if they were patients, or they may have responded as they felt as nurses. Further research should be done to define nurses' perceptions of caring behaviors. The demographic data about nurses included educational preparation, but, because of the small sample size, this study did not link level of education to responses. Research to compare responses between nurses with different levels of education with a larger sample would demonstrate

whether there is a difference in perception of caring behaviors between these nurses with advanced degrees, bachelor's degrees, associates degrees, or diplomas.

Implications for Nursing

The findings of this research indicate that there was agreement between patients' perceptions of caring behaviors and those of nurses. This simply means that patients and nurses share similar understandings of what behaviors demonstrate caring. The perception of caring behaviors was defined by this study. However, the question of whether caring behaviors were demonstrated in the actual experience of the patients was not addressed. This study did not show whether patients felt their individual needs for caring were met.

The results of this study have application in the areas of nursing education, practice, and administration. In nursing practice, caring behaviors by nurses are important to the patient. In this study 29 out of 30 statements were identified by patients as demonstrating caring. Demonstration of caring behaviors by nurses can increase patient satisfaction by meeting an identified patient need. Practicing

caring behaviors can also increase nursing satisfaction by allowing the positive interpersonal relationship to meet the human need of the nurse.

In nursing education and in staff development education caring behaviors should be identified and taught. Previously nurses were often taught to maintain a "professional distance" from the patient. The results of this study show that patients want comfort, encouragement, and understanding from their nurses. Nurses who do not develop an interpersonal relationship with their patients cannot provide what patients need. In basic nursing education, methods of establishing communication, building trusting relationships, and demonstrating caring within the context of a nurse-patient relationship can be taught. In inservices and staff development a focus on caring should be added to the current emphasis on technical skill and productivity.

There are at least two applications to nursing administration. First, it is critical that nurse managers develop tools to identify caring nurses. When choosing from applicants for nursing positions, the nurse manager should be as concerned about caring as he

or she is about competence and other criteria. The technically competent nurse who is uncaring cannot deliver the highest quality of nursing care. Second, the nurse manager must demonstrate caring behaviors toward the nursing staff. It cannot be expected that staff nurses will consistently show caring behaviors to patients in an atmosphere where their leaders demonstrate uncaring behaviors.

Several critical questions went unanswered in this study. Did these patients feel that their nurse exhibited caring behaviors? In a hierarchy of needs, how would patients rank the need for caring behaviors from nurses? How important was it to these nurses that patients' need for caring behaviors be met? What factors have an impact on the ability of nurses to be caring, and on patients to accept caring? Research on these questions would increase the body of knowledge about caring.

There have been several decades of research which defined caring behaviors. Nursing researchers should now look beyond definition, and study how caring affects patients. Future studies should focus on how to measure the impact of caring behaviors on patient

outcomes. Watson (1985) suggests that caring results in transcendence, healing, and harmony, but further nursing research is needed to support her theory.

Appendix A

Appendix A

CARING IN THE EMERGENCY DEPARTMENT

DIRECTIONS: Please read each sentence carefully. Circle in the column the number that you think most describes your feelings about each sentence. If you have any questions, please ask the researcher.

SD=Strongly Disagree; D=Disagree; A=Agree; SA=Strongly Agree

1. The nurse answering my questions means caring to me.	SD	D	A	SA
2. The nurse touching me demonstrates caring.	SD	D	A	SA
3. The nurse providing comfort for me shows caring.	SD	D	A	SA
4. The nurse seeing that I was uncomfortable and asking me what was wrong means caring to me.	SD	D	A	SA
5. The nurse listening to what I said demonstrates caring.	SD	D	A	SA
6. The nurse knowing what I needed without being asked shows caring.	SD	D	A	SA
7. The nurse knowing I was afraid means caring to me.	SD	D	A	SA
8. The nurse closing the curtains demonstrates caring.	SD	D	A	SA
9. The nurse giving me encouragement shows caring to me.	SD	D	A	SA
10. The nurse crying with me demonstrates caring.	SD	D	A	SA
11. The nurse explaining what was being done to me demonstrates caring.	SD	D	A	SA
12. The nurse getting my family for me shows caring.	SD	D	A	SA
13. The nurse standing by my bed means caring to me.	SD	D	A	SA
14. The nurse seeing that I need help means caring to me.	SD	D	A	SA
15. The nurse being patient with difficult patients demonstrates caring.	SD	D	A	SA

SD=Strongly Disagree; D=Disagree; A=Agree; SA= Strongly Agree

16. The nurse recognizing that I am in pain means caring to me.	SD	D	A	SA
17. The nurse knowing how to give a shot shows caring.	SD	D	A	SA
18. The nurse working with the physician to help me shows caring.	SD	D	A	SA
19. The nurse recognizing that I was hurting means caring to me.	SD	D	A	SA
20. The nurse addressing me appropriately demonstrates caring.	SD	D	A	SA
21. The nurse looking at me while talking to me demonstrates caring.	SD	D	A	SA
22. The nurse letting me cry means caring to me.	SD	D	A	SA
23. Being able to recognize who the nurse is demonstrates caring to me.	SD	D	A	SA
24. The nurse providing me with information demonstrates caring to me.	SD	D	A	SA
25. The nurse not leaving me alone means caring to me.	SD	D	A	SA
26. The nurse being able to start my IV shows caring.	SD	D	A	SA
27. The nurse making a phone call for me shows caring.	SD	D	A	SA
28. The nurse trying to understand how I am feeling means caring to me.	SD	D	A	SA
29. The nurse being honest with me demonstrates caring to me.	SD	D	A	SA
30. The nurse doing what I asked when she/he could and explaining to me when she/he could not do what I asked demonstrated caring to me.	SD	D	A	SA

In your own words, describe how you know when the nurse is using caring behaviors.

GRAND VALLEY STATE UNIVERSITY
KIRKHOF SCHOOL OF NURSING

STANDARD RELEASE FORM

I, Renee Semonin-Holleran, hereby give permission to the Grand Valley State University, Kirkhof School of Nursing.

____ 1. To utilize photographs, films, video or audio taped segments of self for educational purposes.

X 2. To copy or reproduce the following material(s) for educational purposes by faculty and/or students within said institution:

Caring in the Emergency Department Questionnaire

___ 3. To use the Caring in the Emergency Department Questionnaire in Marcia Moerman's Master's thesis work

Date: 10/7/95 Signature: [redacted]

Name Printed: Renee S Holleran

Institution/Agency: University Of Cincinnati

Address: 5804 Mt. Vernon

City: Milford

State: Oh Zip: 45150

Witness: [redacted]

Date: 10/7/95

Appendix B

Appendix B

Patient Characteristics

Please fill in your age on the first questions and circle the correct response on the next 4 questions.

1. Age _____

2. Sex
   1. male
   2. female

3. Marital Status
   1. Have never been married
   2. Married
   3. Divorced/Separated
   4. Widow/Widower

4. Ethnic Background
   1. African-American
   2. Asian
   3. Caucasian
   4. Hispanic
   5. other (specify)_____

5. Years of Education completed
   1. less than 9th grade
   2. between 9th and 12th grade
   3. high school graduate
   4. 2 years of college/Associates degree
   5 4 years of college/Bachelors degree
   6. Master's degree
   7. other (specify)_____

Registered Nurses Characteristics

Please write the answer to the first question and circle the correct answer for the next 5 questions

1. Age _____

2. Sex
   1. male
   2. female

3. Marital status
   1. Have never been married
   2. Married
   3. Divorced/Separated
   4. Widow/Widower

4. Ethnic Background
   1. African-American
   2. Asian
   3. Caucasian
   4. Hispanic
   5. other (specify)_____

6. Educational preparation for nursing (circle all that apply
   1. Diploma
   2. Associates degree
   3. Bachelor's degree other than in nursing
   4. Bachelor's degree in nursing
   5. Master's degree other than in nursing
   6. Master's degree in nursing
   7. other (specify)_____

7. Number of years in practice as emergency nurse _____

Appendix C

Appendix C

VERBAL EXPLANATION FOR PATIENTS

My name is Marcia Moerman. I'm a registered nurse and graduate student at Grand Valley State University. I am studying which behaviors demonstrated by nurses that patients think are caring behaviors. The information you give me will be helpful in learning more about nurses' caring behaviors in the emergency department.

I would like you to participate in this research. It would mean that you fill out 2 questionnaires, one which consists of statements about caring behaviors and another which will be used to describe the characteristics of the group participating in the study. You will be asked to mark whether you strongly disagree, disagree, agree, or strongly agree with the statements describing the nurses' behavior. It should take you about 15 minutes to complete the questionnaires.

Whether or not you participate in this study will in no way affect your treatment in the emergency department. Your participation is completely voluntary. Your anonymity will be guaranteed; you will never be identified by name in this study. If you are willing to participate in the study, I would like you to sign a consent form. Do you have any questions?

Appendix D

Appendix D

COVER LETTER FOR RN PARTICIPANTS

Dear Nursing Colleague:

I am Marcia Moerman, a Registered Nurse in the Trauma and Emergency Center and a graduate student at Grand Valley State University. I am conducting research about patients' perceptions of caring behaviors demonstrated by nurses as compared with nurses' perceptions of caring behaviors demonstrated by nurses. As part of this study I would like you to take 15 minutes and fill out a questionnaire which lists behaviors which indicate caring and a brief information sheet. You will mark whether you strongly disagree, disagree, agree, or strongly agree with the statements in the questionnaire.

Participation in this study is voluntary and completion of the questionnaire serves as consent to participate. At no time will you be identified in the study. There will be a box in the breakroom marked "Caring Behaviors Research" where you can place completed questionnaires if you choose to participate, or blank questionnaires if you choose not to participate.

If you are interested in the results of the study please fill out the address sheet in your packet which will be separated from the questionnaire prior to data analysis. I will mail you the results. If you wish to speak to me about this research, please call me at 341-7801 and leave a message. The results will be presented in an inservice when it is completed.Thank you for your help with this research.

Appendix E

GRAND VALLEY STATE UNIVERSITY
1 CAMPUS DRIVE • ALLENDALE MICHIGAN 49401-9403 • 616/895-6611

April 17, 1996

Marcia Moerman
1029 Hol-Hi
Kalamazoo, MI 49008

Dear Marcia:

The Human Research Review Committee of Grand Valley State University is charged to examine proposals with respect to protection of human subjects. The Committee has considered your proposal, "***Caring Behaviors in the Emergency Department***", and is satisfied that you have complied with the intent of the regulations published in the Federal Register 46 (16): 8386-8392, January 26, 1981.

Sincerely,

[redacted]
Paul Huizenga, Chair
Human Research Review Committee

BMH1048 Caring Behaviors in the Emergency Department: Perceptions of Patients and Nurses (MMoerman)

At the April 2, 1996 Meeting of the Expedited Review Committee, BMH1048 and the informed consent document were approved with the following changes:

1. In the consent form delete the last section which includes all paragraphs after "I agree that:..." and replace it with the standard BMH Patient Acknowledgement (Attachment A).

[redacted] 3 Apr 96

Robert H. Hume, M.D., Chairman — Date
Bronson Methodist Hospital
Human Use Committee
252 East Lovell Street
Kalamazoo, MI 49007
(616) 341-7988

cc: MMoerman

Appendix F

Appendix F

Listing of Caring Statements by Patients According to Mean

	Statements about Caring Behavior	Item Number	Mean
1.	Providing comfort means caring.	#3	3.661
2.	Answering questions means caring.	#1	3.500
2.	Seeing I was uncomfortable/asking what's wrong means caring.	#4	3.500
4.	Getting my family means caring.	#12	3.472
5.	Trying to understand how I'm feeling means caring.	#28	3.444
5.	Being honest with me means caring.	#29	3.444
7.	Giving encouragement means caring.	#9	3.417
8.	Explaining what was being done means caring.	#11	3.389
8.	Being patient with difficult patients means caring.	#15	3.389
10.	Listening to what I said means caring.	#5	3.361
11.	Seeing that I need help means caring.	#14	3.333
11.	Knowing that I was afraid means caring.	#7	3.333
13.	Looking at me while talking to me means caring.	#21	3.306
13.	Doing what I asked when he/she could/ explaining when he/she couldn't means caring.	#30	3.306

13.	Knowing what I needed without being asked means caring.	#6	3.306
16.	Knowing how to give a shot means caring.	#17	3.278
16.	Providing information means caring.	#24	3.278
16.	Touching me means caring.	#2	3.278
19.	Making a phone call means caring.	#27	3.250
19.	Recognizing that I was hurting means caring.	#19	3.250
21.	Recognizing that I am in pain means caring.	#16	3.222
22.	Being able to start my IV means caring.	#26	3.194
22.	Addressing me appropriately means caring.	#20	3.194
24.	Standing by my bedside means caring.	#13	3.167
25.	Working with the physician means caring.	#18	3.139
26.	Closing the curtain means caring.	#8	3.056
26.	Recognizing who the nurse is means caring.	#23	3.056
28.	Crying with me means caring.	#10	3.028
29.	Not leaving me alone means caring.	#25	3.000
30.	Letting me cry means caring.	#22	2.944

Appendix G

Appendix G

Listing of Caring Statements by Nurses According to Mean

	Statements about Caring Behavior	Item Number	Mean
1.	Providing comfort means caring.	#3	3.609
2.	Seeing that I was uncomfortable/ asking what was wrong means caring.	#4	3.435
3.	Explaining what was being done means caring.	#11	3.348
4.	Giving encouragement means caring.	#9	3.304
4.	Knowing what I needed without being asked means caring.	#6	3.304
4.	Listening to what I said means caring.	#5	3.304
7.	Trying to understand what I'm feeling means caring.	#28	3.261
8.	Knowing that I was afraid means caring.	#7	3.217
8.	Recognizing that I'm in pain means caring.	#16	3.217
8.	Being patient with difficult patients means caring.	#15	3.217
8.	Getting my family means caring.	#12	3.217
8.	Touching me means caring.	#2	3.217
13.	Seeing that I need help means caring.	#14	3.174

13.	Recognizing that I was hurting means caring.	#19	3.174
13.	Looking at me while talking to me means caring.	#21	3.174
16.	Answering questions means caring.	#1	3.130
16.	Making a phone call for me means caring.	#27	3.130
16.	Doing what I asked when he/she could/ explaining to me when he/she couldn't means caring.	#30	3.130
19.	Crying with me means caring.	#10	3.087
19.	Providing me with information means caring.	#24	3.087
19.	Being honest with me means caring.	#29	3.087
19.	Closing the curtain means caring.	#8	3.087
23.	Letting me cry means caring.	#22	3.043
24.	Addressing me appropriately means caring.	#20	3.000
24.	Not leaving me alone means caring.	#25	3.000
26.	Working with physician means caring.	#18	2.739
27.	Standing by my bed means caring.	#13	2.609
28.	Knowing how to give a shot means caring.	#17	2.522
29.	Recognizing who the nurse is means caring.	#23	2.478
30.	Being able to start my IV means caring.	#26	2.261

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