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Patient Perceptions of Nurse Behaviors as Indicators of Caring

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PATIENT PERCEPTIONS OF NURSE BEHAVIORS AS INDICATORS OF CARING

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ABSTRACT

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The purpose of this study was to identify which nursing behaviors were perceived by the patient who has undergone coronary artery bypass grafting (CABG) as the most important and least important indicators of caring. In this descriptive study, the Caring Behaviors Assessment (CBA) was administered to 25 CABG patients. This research was a partial replication of a previous study by Cronin and Harrison (1988).

Jean Watson's theory of human care (1985) served as the theoretical framework for this study. The CBA items, ordered in seven subscales, are congruent with Watson's (1985) carative factors.

In this study, the 63 CBA items were ranked from most to least important according to mean scores. Nursing behaviors perceived by the patients in this study as most indicative of caring centered around the monitoring of patient condition and the demonstration of professional competence through technical skill. There were no significant relationships between demographic data and any of the CBA items. These findings are consistent with the results of the Cronin and Harrison (1988) study.

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CHAPTER ONE

INTRODUCTION

Caring has emerged as a significant concept for the nursing profession. Caring has influenced nursing theory, research, and practice. Five major conceptualizations of caring were analyzed by Morse, Bottorff, Neander, and Solberg (1991). Their analysis revealed that the concept is underdeveloped and often lacks relevance for nursing practice. Although caring is not unique to nursing practice, (other professions can be considered caring professions), caring has been described as the essence of nursing and its central, unifying feature (Leininger, 1977). Theories of caring exist and are used as a basis for nursing practice. However, the concept of caring lacks empirical validation. Ben-Sira (1990) has stated that the nursing profession loses legitimacy if caring has no behavioral outcomes.

The main focus of caring research with behavioral outcomes has centered on home health agencies and secondary care settings. Prior to the study by Cronin and Harrison (1988), little research had been done of the caring process in acute care settings. Cronin and Harrison (1988) described nurse caring behaviors as identified by patients who had a myocardial infarction. As part of their research, they developed the caring behaviors assessment (CBA) tool (Appendix A) based upon Watson's (1985) ten carative factors.

Since 1988, the CBA tool has been administered to various populations in acute care settings.

It is believed that effective caring promotes health and a higher level of wellness (Cronin & Harrison, 1988). In order to promote health and wellness, more research is needed to understand which nursing behaviors are considered caring behaviors by the patient. The purpose of this study was to identify which nursing behaviors were perceived by the patient who had undergone coronary artery bypass grafting (CABG) as the most important and least important indicators of caring. In this study, the CBA tool was administered to patients who had undergone CABG. This study adds to the body of knowledge regarding caring theory and specific caring activities through partial replication of the Cronin and Harrison (1988) study.

CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Theoretical Framework

Jean Watson's theory of human care (1985) served as the theoretical framework for this study. According to Watson (1985), nursing attempts to understand how health, illness, and human behavior are interrelated. Watson's theory focuses on moment to moment encounters between the one giving care and the one being cared for (Fawcett, 1993). Watson views caring as a nursing term and as an outcome of scientific activity that represents the factors the nurse uses to deliver health care to the patient. In order to deliver this care, the patient and nurse come together in a "caring occasion" (Watson, 1985). In this study, caring is defined as "the process by which the nurse becomes responsive to another person as a unique individual, perceives the other's feelings, and sets that person apart from the ordinary" (Cronin & Harrison, 1988, p. 376).

According to Watson, person is defined as "a being-in-the-world [which] is the locus of human existence. Person exists as a living, growing gestalt. The person possesses three spheres of being - mind, body, and soul - that are influenced by the concept of self" (Watson, 1985, p. 54). Within this study, person is the patient who has undergone

coronary artery bypass grafting (CABG) surgery. The person (patient) was selected based upon predetermined criteria and is considered to have come together with the nurse in a "caring occasion" (Watson, 1985). A second person existed in this study, the nurse. The nurse and the patient make a caring occasion. Both patient and nurse were considered "beings in the world" and comprised the "caring occasion" (Watson, 1985). The patient determined which CBA behaviors were the most and least important indicators of caring.

Environment is not well developed by Watson (1985). Therefore, the conceptualization must be inferred (Boyd & Mast, 1989). It is inferred that environment is part of a person's external world that includes nature and external reality. The patient's external environment in this study is the cardiothoracic step up unit (CTSU).

Watson (1985) states that health is more than the absence of disease, rather it is "a unity and harmony within the mind, body, and soul" (p.49). In close association with this definition is the belief that nursing is viewed as a "human science of person and human health-illness experiences that are mediated by professional, personal, scientific, and ethical human care transactions" (Watson, 1985, p. 54).

The link between the definition of health and the concept of nursing is the nursing process. The nursing goals are to help patients gain a higher degree of harmony within the mind, body, and soul which "generates self-knowledge,

self-reverence, self-healing, and self-care processes" (Watson, 1985, p. 49). The goals are attained through a human caring process and interventions that Watson (1985) describes as carative factors.

The ten carative factors are believed to be used by the patient and the nurse to find meaning in disharmony and promote choice and self-determination in health-illness decisions, assisting the patient to a perceived harmony between mind, body, and soul (Boyd & Mast, 1989). The perceived harmony is the health for the particular patient. Nursing interventions, or carative factors, are considered to be necessary in the nurse-patient relationship in order for harmony to be attained.

Watson (1985) identifies the 10 carative factors as

(a) the formation of a humanistic-altruistic system of values, (b) the installation of faith-hope, (c) the cultivation of sensitivity to one's self and to others, (d) the development of a helping-trust relationship, (e) the promotion and acceptance of the expression of positive and negative feelings, (f) the systematic use of the scientific problem-solving method for decision making, (g) the promotion of interpersonal teaching-learning, (h) the provision for a supportive, protective, and corrective mental, physical, sociocultural, and spiritual environment, (i) assistance with the gratification of human needs, and (j) the allowance of existential-phenomenological forces (p. 75).

Although the carative factors have a nonrelational aspect, Watson (1985) believes each preceding factor contributes to the next and interacts to promote nursing care. The Watson carative factors provided the conceptual basis for this study.

Theoretical Definitions. Based on the theory of caring as a means to harmony of the person, the carative factors were used to define the study variable: perceptions of nurse behaviors as the most and least important indicators of caring.

Caring is "the process by which the nurse becomes responsive to another person as a unique individual, perceives the others' feelings, and sets that person apart from the ordinary" (Cronin & Harrison, 1988, p. 376).

Nurse behaviors are "those things that a nurse says or does that communicate caring to the patient" (Cronin & Harrison, 1988, p. 376).

There is one variable for this study: perceptions of nurse behaviors as the most and least important indicators of caring. This was considered an end in itself. The researcher recognizes that a relationship exists between Watson's (1985) carative factors and transpersonal caring. Although it is acknowledged, the relationship is not a part of this study.

Research Questions. The research questions generated from the theory of human care (Watson, 1985) are based upon a partial replication of a study by Cronin and Harrison (1988).

The Cronin and Harrison (1988) study described the importance of nurse caring behaviors as perceived by patients after myocardial infarction. It identified nurse behaviors that were considered the most and least important indicators of caring.

Administration of the CBA and collection of demographic data were used to answer the study questions. This study asked two questions: (a) which nurse caring behaviors are perceived by patients who have undergone CABG as the most and least important indicators of caring, and (b) do perceptions of nurse caring behaviors differ according to gender, age, marital status, educational level, income level, and number of prior hospital admissions in the preceding year?

Significance to Nursing. The results of this study added to the body of knowledge of caring behavior by identifying which nurse behaviors the patient perceives as the most and least important indicators of caring. Watson (1989) claimed that her theory encompassed the whole of nursing with emphasis on the interpersonal process between patient and nurse. According to Watson (1985), the goal of nursing is to help persons gain a higher degree of harmony of the mind, body, and soul. The identification of nurse behaviors that the patient perceives as important indicators of caring will provide nursing with additional information for the application of the carative factors. By knowing which carative factors are perceived by the patient as most

indicative of nurse caring, the nurse and patient can come together to achieve a higher degree of harmony. This study assists in bridging the gap between theory and practice.

Literature Review

This literature review examines relevant information regarding research on caring theory and its place in the discipline of nursing and an empirical review. The theoretical and empirical literature review is a historical perspective and reviews the state of the current status of caring in the literature. Additionally, the empirical review is within nursing specialties and reviews studies in which nursing behaviors are considered the most and least important indicators of caring from the patient perspective.

Theoretical Review. Caring has received acceptance as a part of nursing practice, but has received little comment as to its relevance to the practice. Morse, Bottorff, Neander, and Solberg (1991) compared five major conceptualizations of caring: (a) caring as a human trait, (b) caring as a moral imperative, (c) caring as an affect, (d) caring as an interpersonal interaction, and (e) caring as a therapeutic intervention. It was the purpose of their analysis to determine if caring is able to be reduced to behavioral tasks. Their comparison reveals that theorists who regard caring as a moral ideal agree that caring cannot be reflected in technique. These theorists believe that caring is the point from which the nurse intervenes. The intervention

motivated from caring is the influence of judgment, decision making, and action. Brody (1988) has stated that "it is not just the competent performance of technical skills that evokes the image of caring, but the compassionate attitudes and feeling of the nurses toward the patient as they perform their tasks that is the essence of caring" (p. 92).

Theorists who view caring as an affect believe that caring involves being with the patient rather than doing to the patient (Forrest, 1989). Morse, Bottorff, Neander, and Solberg (1991) conclude that theorists who support caring as a therapeutic intervention consider caring to be specific nursing actions. Brown (1986) and Orem (1985) are specific in stating caring tasks. Leininger (1981) and Swanson (1988) are more global in the delineation of caring. There were no clear conclusions among the theorists as to whether caring affected the patient, the nurse, or both. The exceptions are the theorists who view caring as a therapeutic intervention. Nurse outcomes are identified by Benner and Wrubel (1989) as personal enrichment. Griffin (1983) discusses nurse outcomes as increased understanding, emotional capacity, and a sense of personal worth. Research by Forrest (1989) reveals that the nurse outcomes result in increased emotional burdens to the nurse.

Mutual outcomes are identified by Bevis (1981) as self-actualization, by Gadow (1985) as enhanced subjectivity, and by Watson (1985) as increased spirituality. Watson (1985)

stated, "In a transpersonal caring relationship a spiritual union occurs between the two persons where both are capable of transcending self, time, space and the life history of each other" (p.66).

Caring, described as patient outcomes, includes enhanced health, well being, comfort, and patient satisfaction. Theorists who describe patient outcomes of caring believe the goal of caring is to effect a desirable outcome in the patient. In other words, an actual physical response that could be measured. Morse, Bottorff, Neander, and Solberg (1991) concluded that a loose link remains between caring definitions and patient outcomes. They concluded that the concept is underdeveloped and does not encompass all the components of caring that are relevant to clinical practice. Kyle (1995) also reviewed the various theoretical perspectives of caring. Kyle, however, added to the theoretical aspect by examining the strengths and limitations of the qualitative and quantitative approaches to caring measurement.

Watson (1987) discussed the changing direction of nursing. She identifies a moral ideal of human caring that addressed the traditional medical treatment model. Through her paper she supports her theory of caring as a moral ideal. Caring as a moral ideal in nursing theory has not been without criticism. Fawcett, George, and Walker (1989) presented varying opinions in reviewing Watson's theory

(1985). Fawcett argues that the theory of human caring contributes to the understanding of a process by which nursing can effect positive changes in a patient's health state. George (1989) criticizes the theory for its limited connections to other phenomenological nursing theory. She further believes that the consistent level of abstraction in caring theory makes it difficult to quantify. Walker (1989) supports George (1989) by finding difficulty in merging the abstraction into quantifiable methodology. All three critics agree that caring as a nursing theory and as a measurable act requires more consideration and research.

Empirical Review. A doctoral dissertation by Henry (1975) provides one of the earliest studies in exploring caring behavior. Open ended interview questions were posed to 50 home health patients. They were asked to identify nursing behaviors that indicated caring. The 211 responses were classified into what the nurse does, how the nurse does, and how much the nurse does. The largest number of responses identified "how the nurse does" as an indicator of caring behavior. The words patient, gentle, friendly, interested, kind, and considerate were used by the patient to describe the nurse behavior. Although frequencies of responses were reported, no exploration of importance was given to the identified behaviors.

Watson, Burckhardt, Brown, Bloch, and Hester (1979) conducted a descriptive study that classified caring

behaviors. This study is one of the first to look at caring from the patient and nurse perspective. The study cites similarities and differences between patients' and nurses' descriptions of caring behavior. This study generated questions for research and further testing. A convenience sample of 17 patients, 19 nurses, and 14 nursing students were administered an open ended questionnaire. The results reveal that patients identify activities involving physical care and comfort as reflective of caring. The nurses and nursing students identify more affective dimensions of care. This difference supports the need for further research, but lacks in its identification of importance of the identified behaviors.

Research by Brown (1982) used a Likert-type scale with 80 acute care patients to rate the importance of nursing behaviors. The patients were asked to rate the importance of nursing behaviors as indicators of care. The patients were also asked to describe what nurses do or say to make them feel cared for and about. The results reveal a combination of what the nurse did and what the nurse was like as a person as indicative of caring. Behaviors that are considered to be fundamental to perceptions of caring center on physical well-being as well as on the affective component.

These early studies of caring research developed the area of patient satisfaction and attempt to correlate caring and caring behavior with patient satisfaction of nursing

care. Bond and Thomas (1992) suggest that a flaw exists in the study of patient satisfaction. They argue that there is a lack of systematic research and appropriate measurement selection, thus making it impossible to draw substantive conclusions until more reliable and valid measures of patient satisfaction are documented. This conclusion is supported by Megivern, Halm, and Jones (1992). Their research attempts to develop and implement a reliable and valid measurement tool to measure patient satisfaction as an outcome of nursing care. Later research by Larson and Ferketich (1993) uses an empirically derived satisfaction measurement instrument, the Care/Satisfaction Questionnaire (CARE/SAT). A dilemma resulted from empirical measurement. The researchers question what instrument categorization would be most representative of the caring domains of nursing. They conclude that researchers must be specific in what is being measured and that different tools are appropriate to different research. Measuring patient satisfaction continues to be a dilemma for nursing researchers. Lin (1996) concludes that it appears presumptuous to consider patient satisfaction as an indicator of quality of nursing care or as an outcome variable in nursing evaluation research. She supports this conclusion through evaluation of patient satisfaction instruments. As a result, she suggests that most instruments fail to provide strong evidence for validity. She further concludes that several factors could influence patients' judgments of their

satisfaction, including timing of survey, response format, and nonrespondence. Lin (1996) also reveals a lack of a consistent conceptualization and an appropriate theoretical framework to correlate patient satisfaction and quality of nursing care.

Watson and her colleagues have attempted to study the concept of caring by collecting data to use in classifying caring behaviors, to describe the similarities and differences between what nurses consider and what patients consider to be caring behaviors (1979). Their conclusions stress the need for further study in order to clarify what behaviors and values are important from each viewpoint. As caring research has developed and expanded, the studies have become less global and more specialty focused.

Oncology nursing has long been considered a focus of caring behavior. A review of oncology literature demonstrates that the caregiving role continues to be challenged in an evolving high tech world (Larson, 1995). A hallmark study by Larson (1984) first identified the perception of nurse caring behaviors by patients with cancer. Larson (1984) was able to quantify patients' perceptions of caring by the Caring Assessment Instrument (CARE-Q) and reveals that patients give the highest ranking to caring items that reflect skill, knowledge, and judgment abilities of the nurse. Mayer (1987) conducted a replication of the study and was able to correlate caring and curing. The components of caring

behavior include attributes of the caregiver, the caring process, and the actual behaviors one performs to make the patient feel cared for and about. As in the earlier work by Larson (1984), nurse caring behaviors are ranked according to importance by 28 oncology nurses and 54 cancer patients utilizing the CARE-Q instrument. The research reveals a significant correlation ($p<.01$) between patients' and nurses' perceptions of the 50 behaviors. There are differences between patients and nurses in specific behaviors and in the most and least important behaviors. Nurses rank empathic qualities and patients rank technical qualities (ability to give shots, IV's, etc.) as the most important behavior to indicate caring. These same findings are consistent with the earlier study by Larson (1984).

Like oncology nursing, home care nursing has been a focus of research for caring behaviors and caring perceptions. Poole and Rowat (1994) examined perceptions of elderly home-care clients through a descriptive study. Five home-care clients were studied over a two to five month period. The results reveal that caring for elderly clients receiving home nursing services is perceived in terms of the affective behaviors of the nurse, which they define as the attributes of the nurse. They also suggest that care is perceived as the nurse giving emotional and physical support, but the greatest emphasis is placed on the nurses' attributes. Although a small sample size was used, this

supports earlier research by Henry (1975), Brown (1986), and Bowman (1988) in defining caring in terms of the attributes, or affective behaviors, of the nurse. However, Poole and Rowat (1994) state that this study is consistent with nursing literature that suggests that nurse attributes are perceived as caring "across nursing contexts" (p.427). This may be true in terms of definitions, but in ranking the importance of nursing behaviors as indicators of caring, the past research has placed behavioral tasks and affective nursing behaviors (attributes) on the same plane of importance (Bowman, 1988; Brown, 1986; Hull, 1991; Larson, 1984; Mayer,1987; Paternoster, 1988; Sloan, 1986).

Acute care setting research also focuses upon nurse caring behaviors. Cronin and Harrison (1988) studied the importance of nurse caring behaviors as perceived by patients after myocardial infarction. This research serves as the seminal study upon which subsequent studies are based. Cronin and Harrison (1988) interviewed 22 hospitalized patients with the use of open ended questions and the Caring Behavior Assessment (CBA). The purpose was to determine what things nurses said and/or did that conveyed caring to the patient in the Coronary Care Unit (CCU). Specifically, they addressed three questions: (a) what behaviors exhibited by nurses in the CCU were perceived by patients with myocardial infarction as indicators of caring, (b) which nurse caring behaviors were perceived as most important and least important by

patients with myocardial infarction, and (c) do perceptions of nurse caring behaviors differ according to sex, age, educational level, number of CCU admissions, or length of CCU stay? The nursing behaviors perceived as most indicative of caring by the patients in this study were centered on the monitoring of patient condition and the demonstration of professional competence. These findings are consistent with those of Brown (1982), Larson (1984), and Mayer (1986). Cronin and Harrison (1988) further conclude that certain minimum care requirements must be met before patients attend to the non physical aspects of care. This is consistent with the hierarchy of human needs by Maslow (1943), later advanced by Watson (1979).

Cronin and Harrison (1988) provided significant research potential through the development of the CBA tool. The original tool consisted of 61 nursing behaviors ordered in seven subscales that were congruent with Watson's carative factors (1985). With use of a five-point Likert-type scale, patients were asked to indicate the degree to which each listed behavior communicated caring. The Cronin and Harrison (1988) study and the CBA have served as a source of replication and application in subsequent research.

Huggins, Gandy, and Kohut (1993) did a descriptive study to identify which behaviors performed by emergency department nurses were perceived by patients as important indicators of caring. They utilized the CBA for instrumentation. The

results are consistent with those of Cronin and Harrison (1988) in that the greatest importance is placed on technical nursing behaviors as indicators of nurse caring. This is a significant finding because of the sample size. A total of 288 patients were studied as compared to the 22 patients in the previous study by Cronin and Harrison (1988). It should be noted, however, that the larger sample was triaged as part of the emergency room admission, and patients in the urgent triage group (n=99) identified fewer caring behaviors that the nurse must perform to demonstrate caring than did patients in the non-urgent group.

Parsons, Kee, and Gray (1993) studied perioperative nurse behaviors as perceived by selected surgical patients to determine if any of the identified behaviors were more important than others. A secondary purpose of their research was to contrast the findings with the earlier work by Cronin and Harrison (1988). Comparison of the 19 subjects in this study with the 22 in the Cronin and Harrison (1988) study reveals similarities in ratings of the most important and least important items on the CBA. This result is consistent with previous studies (Cronin & Harrison, 1988; Huggins, Gandy & Kohut, 1993) in that the patients ranked the item "nurses know what they are doing" as most important. Differences between the Cronin and Harrison (1988) study and the Parsons, Kee, and Gray (1993) study were accounted for by the perceived life threat in each population. The myocardial

infarction patient had experienced a life threatening event, while the surgical patients perceived the surgical procedure as less threatening.

The gap between theory and practice continues to be a nursing issue and is being developed along separate paths. Further study is needed to develop, refine, and validate caring theory and the empirical studies that support the theory. Based upon Watson's earlier works (1979), empirical studies have attempted validation of caring as a nursing theory. The present study adds to the body of knowledge by addressing the following questions: (a) which nurse caring behaviors are perceived by patients who have undergone CABG as the most and least important indicators of caring, and (b) do perceptions of nurse caring behaviors differ according to gender, age, marital status, educational level, income level, or number of prior hospital admissions in the preceding year?

CHAPTER THREE

METHODOLOGY

Research Design

This research utilized a descriptive design to identify which nursing behaviors are perceived by patients who have undergone CABG as the most and least important indicators of caring. Data were collected through administration of the Caring Behaviors Assessment questionnaire (CBA) (Cronin & Harrison, 1988). The design was based upon a partial replication of the Cronin and Harrison study (1988). The Cronin and Harrison research (1988) focused upon nursing behaviors as perceived by myocardial infarction patients in a coronary care unit.

There was one primary focused variable in this study: perceptions of nurse behaviors as most and least important indicators of caring. Although they were not be measured, there are certain inherent variables which may have influenced the subjects' responses to the CBA. Watson (1985) describes these variables as the person's phenomenal field. It is the phenomenal field that, Watson (1985) explains, the individual brings to each occasion and thus, influences each patient's response. These influences are a result of each person's unique past that is incorporated into the present moment (Watson, 1985). These influences may be the subject's

experiences of health and illness, developmental conflicts, inner suffering, guilt, self-blame, loss, grief, and stress (Watson, 1985).

Sample and Setting

The sampling method for this study was a convenience sample of 25 patients with no attempt at randomization. The average CABG caseload at the participating hospital was three to four cases per day. Twenty five questionnaires were distributed. All questionnaires were completed and returned within two weeks of distribution. Demographic data were obtained that included gender, age, marital status, educational level, income level, and number of prior hospital admissions in the preceding year (see Appendix B).

Prior to data collection, the study proposal was approved by the Grand Valley State University Human Research Review Committee and the Internal Review Board of Munson Medical Center. There were no anticipated risks to this study.

All subjects were identified during their inpatient admission at Munson Medical Center, a 368 bed, acute care medical center in northwestern Michigan. Criteria for subject inclusion were: (a) a patient who had undergone coronary artery bypass grafting surgery, (b) same day admission for CABG surgery, (c) transferred from the cardiothoracic unit (CTU) to cardiothoracic stepup unit (CTSU) on post operative day one, (indicative of an uncomplicated immediate post

operative course), (d) no history of inpatient admission within 30 days prior to CABG, (e) ability to speak, read, and understand English, and (f) planned discharged from the CTSU within seven days of CABG. Patients of all ages were considered for inclusion.

With the exception of age, the demographic characteristics are summarized in Table 1. Age of the participants ranged from 37 to 82 years (M=60.5; SD=11.8). Educational levels ranged from less than high school education (n=5) to a masters or Ph.D.(n=2). Thirty six percent (n=9) were high school graduates. The participants consisted of 40% (n=10) male and 56% (n=14) female. There was a 4% (n=1) missing value. The missing value was unable to be identified for gender because of subject anonymity. Eighty eight percent (n=22) of the subjects were married. Twenty-eight percent (n=7) had income levels of $21,000 to 40,000. Sixty percent (n=15) of the subjects had no hospital admissions in the preceding year and 36% (n=9) had 1 to 5 admissions.

Table 1

Demographic Characteristics (N=25)

Characteristic	Frequency	Percent
Education		
< High School	5	20
High School	9	36
Tech/Coll Classes	5	20
College Graduate	2	8
Master's Classes	2	8
Master's/PhD Graduate	2	8
Gender		
Male	10	40
Female	14	56
Missing Data	1	4
Current Marital Status		
Divorced	2	8
Widowed	1	4
Married	22	88
Annual Income		
0-20,000	6	24
21,000-40,000	7	28
41,000-60,000	4	16
61,000-80,000	4	16
>80,000	4	16
Admissions in Past Year		
0	15	60
1-5	9	3
Missing Data	1	4

Procedure

Subject recruitment occurred prior to hospital discharge. Potential subjects were identified from chart review for fulfillment of study criteria. Those who met criteria were introduced to the study's purpose and format. Consent to participate was through verbal agreement. Demographic and instrument completion implied consent. The subject was given a written confirmation (see Appendix C) of the explanation regarding the study's purpose and assurance of confidentiality and anonymity. Upon obtaining consent, the researcher asked the subject, "While in the CTSU, what things did nurses say or do that made you feel cared for and about?" This open ended question was asked prior to instrument distribution. It was included to elicit perceptions of care indicators that may not be reflected on the CBA. Responses to the question were written verbatim by the researcher and read back to the participant to assure accuracy. Only the researcher knew of the subject's agreement to participate in this study unless the subject chose to share the information.

The CBA, personal data sheet, and written confirmation of verbal script were distributed to the subject prior to discharge. The setting for instrument completion was determined by the subject. The subject was assured that completion was not necessary in one sitting and could be done at a convenient time. The subject was asked to return the

completed instrument and personal data sheet within two weeks following hospital discharge. The subject was given a self addressed stamped envelope for data return.

Instrument

A personal (demographic) data sheet was completed by the subject at the time of instrument completion. There was one instrument used in this study. The Caring Behaviors Assessment (CBA) was developed by Cronin and Harrison (1988) to assess the contribution of identified nursing behaviors to the subject's sense of feeling cared for and about, and the importance the subject places upon the identified behaviors.

The original CBA listed 61 nursing behaviors, ordered in seven subscales. After the 1988 publication of study results by Cronin and Harrison (1988), two items were added to the questionnaire to make a total of 63 identified nursing behaviors. The complete CBA by item number is found as Appendix A. The subscales are congruent with Watson's carative factors (1985). Watson's carative factors (1985) and the CBA subscales with their respective item numbers are illustrated in Table 2.

Table 2

Relationship of Watson's Carative Factors to CBA Tool

Watson Carative Factor	Subscale	CBA Item
1,2,3	Humanism/Faith-hope/Sensitivity	1-16
4	Helping/Trust	17-27
5	Expression of Positive/Negative Feelings	28-31
7	Teaching/Learning	32-39
8	Supportive/ Protective/ Corrective Environment	40-49
9	Human Needs Assist	52-60
10	Existential/ Phenomenological/ Spiritual Forces.	61-63

The first three carative factors were grouped into one subscale. This subscale was determined by Cronin and Harrison (1988) to be conceptually congruent with Watson's model. The sixth carative factor, use of a creative problem-solving caring process, was assumed by Cronin and Harrison (1988) to be inherent to all aspects of nursing care, making it imperceptible to patients. Therefore, this factor was omitted from the instrument. The remaining carative factors were

identified with a subscale comprised of theoretically congruent items from the CBA.

The CBA is written at the sixth grade level, as determined by the Flesch Readability Formula and the Fog formula (Cronin & Harrison, 1988). Face and content validity were established by a panel of four content specialists familiar with Watson's theory of nursing care (1985). Congruence of each behavior with its given subscale was rated by the panel and those items with interrater reliabilities of less than .75 were recategorized into more appropriate subscales. Items 50 (are gentle with me) and 51 (are cheerful) were added to the Supportive/Protective/Corrective Environment subscale after the original study. Therefore, the reported alpha coefficients do not include these items.

Internal consistency was determined in the original application of the instrument by using the study sample responses to calculate Cronbach's alpha for each of the seven subscales. The subscales with the number of CBA items in each subscale, the previously established reliabilities (Cronin & Harrison, 1988), and the coefficients of internal consistency reliabilities in this study are summarized in Table 3. Reliability analysis on all 63 items was not identified in the Cronin and Harrison (1988) study. For this study, the overall alpha was .96. Reliability coefficients for the subscales ranged from .66 to .90 in the Cronin and Harrison (1988) study. The reliability coefficients in this study

ranged from .63 to .87.

Table 3

Summary of Subscale with Number of CBA Items and Corresponding Previous and Current Reliabilities Coefficients

Subscale	# of CBA Items	Cronbach alpha Cronin and Harrison (1988)	Cronbach alpha Current Study
Humanism/Faith/ Hope/Sensitivity	16	.84	.86
Helping/Trust	7	.76	.87
Expression of Positive/Negative Feelings	4	.67	.87
Teaching/Learning	8	.90	.80
Supportive/ Protective/ Corrective Environment	10	.79	.79
Human Needs Assist	9	.89	.72
Existential/ Phenomenological/ Spiritual Forces.	3	.66	.63

The lower reliabilities of the last subscale were attributed to the type of subscale (Existential/Phenomenological/Spiritual Forces) and the idea that the elusive character of the topic may not be quantifiable. Consideration could be given to the small number of items in the subscale (n=3). However, the

Expression of Positive/Negative Feelings subscale had a small item number (n=4) and had a Cronbach alpha of .67 in the Cronin and Harrison (1988) study and .87 in this study.

Subjects were asked to complete the 63 item CBA by indicating the degree to which each behavior communicated caring to them. This was indicated on a five point Likert-type scale with five giving much importance to a nursing behavior and one giving little importance to a nursing behavior. The potential range of scores for each participant was 63 to 315. The actual scores and their significance are discussed in the following chapters.

CHAPTER FOUR

RESULTS

The purpose of this research was to identify which nursing behaviors were perceived by the patient who had undergone coronary artery bypass grafting (CABG) as the most and least important indicators of caring. Data analysis for this study was completed using the Statistical Package for Social Sciences (SPSS) software. Significance was set at $p < .05$ for all tests.

Two questions were posed in this study: (a) which nurse caring behaviors are perceived by patients who have undergone CABG as the most and least important indicators of caring, and (b) do perceptions of nurse caring behaviors differ according to gender, age, marital status, educational level, income level, and number of prior hospital admissions in the preceding year?

The range of scores on the 63 item CBA was from 175 to 315. To identify the most and least important indicators of caring, CBA items were ranked from most to least important according to mean scores. Means ranged from a high of 4.92 for the two most important items (know how to handle equipment and know how to give shots, IVs, etc.) to a low of 2.48 and 3.08 respectively for the two least important items (visit me if I move to another hospital unit and talk to me

about my life outside the hospital). Three CBA items had missing data. These were evaluated and determined to be random. Considering the small number of missing data and the small sample size, the missing data were substituted with the mean value for those items (Polit & Hungler, 1995, p.497). A complete ranking with means for all 63 items is found as Appendix D. A summary of the subjects' perceptions of the ten most important and ten least important nurse caring behaviors is found in Table 4 and Table 5 respectively.

Table 4

Summary of Subjects' Perceptions of The Ten Most Important Nurse Caring Behaviors

Item	% of Respondents Perceiving the Item as Most Important	Mean
Know how to handle equipment (CBA 54)	92	4.92
Know how to give shots, IVs, etc. (CBA 53)	92	4.92
Know when it's necessary to call the doctor (CBA 60)	84	4.84
Give my treatments and medications on time (CBA 55)	84	4.84
Answer my questions clearly (CBA 33)	88	4.84
Know what they're doing (CBA 3)	88	4.84
Give my pain medication when I need it (CBA 45)	80	4.80
Make me feel someone is there if I need them (CBA 5)	80	4.68
Treat me with respect (CBA 16)	72	4.64
Be kind and considerate (CBA 13)	72	4.64

Table 5

Summary of Subjects' Perceptions of The Ten Least Important Nurse Caring Behaviors

Item	% of Respondents Perceiving the Item as Least Important	Mean
Visit me if I move to another hospital unit (CBA 25)	32	2.48
Talk to me about my life outside the hospital (CBA 20)	20	3.08
Touch me when I need it for comfort (CBA 26)	28	3.20
Ask me what I like to be called (CBA 21)	16	3.24
Consider my spiritual needs (CBA 49)	20	3.28
Encourage me to believe in myself (CBA 6)	4	3.72
Are gentle with me (CBA 50)	3	3.80
Help me feel good about myself (CBA 63)	4	3.80
Help me see that my past experiences are important (CBA 62)	4	3.80
Try to see things from my point of view (CBA 2)	4	3.84

CBA items with their mean score were placed into the appropriate subscale. Overall item means for each of the seven subscales were calculated. The seven subscales were ranked from most to least important according to mean scores. Table 6 illustrates the rankings of the subscales in this study and in the previous study by Cronin and Harrison (1988).

Table 6

Rankings of the CBA Subscales

Study Rank	Cronin and Harrison Rank	Subscale	Study Mean	Cronin and Harrison Mean
1	1	Human Needs Assistance	4.63	4.60
2	2	Teaching/Learning	4.44	4.39
3	3	Humanism/Faith-Hope/ Sensitivity	4.31	4.30
4	5	Supportive/Protective/ Corrective Environment	4.20	4.12
5	7	Expression of Positive/ Negative Feelings	4.10	3.80
6	4	Existential/ Phenomenological/ Spiritual Forces	3.99	4.18
7	6	Helping/Trust	3.87	3.88

Demographic data were used to answer the second question. Pearson's R Correlation was used to evaluate the

relationship between age and the subscales and age and each CBA item. There were no significant relationships between any of the demographic characteristics and subscale scores. Further analysis was done by independent t-testing and the Spearman Rho formula. There were no significant relationships between any of the demographic characteristics and caring behaviors.

The open ended question asked to each subjects was, "While in the CTSU, what things did nurses say or do that made you feel cared for and about?". Five subjects answered the question. The responses included words such as encouragement, reassurance, and explaining procedures. These responses were used to provide a broader perspective of caring.

CHAPTER FIVE

DISCUSSION

Nursing behaviors perceived by the patients in this study as most indicative of caring centered around the monitoring of patient condition and the demonstration of professional competence through technical skill. This result is consistent with those of the Cronin and Harrison (1988) study. Further, the nursing behaviors perceived as the least indicative of caring reflected aspects of personalized care. For example, "visit me when I move to another hospital unit" (CBA item 25) and "talk to me about my life outside the hospital" (CBA item 20) were perceived by the patients as the two least important indicators of caring. This finding is also very similar to those of the Cronin and Harrison study (1988). The priority ranking of the Human Needs Assistance subscale is congruent with the findings of the Cronin and Harrison (1988) study. There were no significant relationships between subjects' age, gender, marital status, income level, educational level, and number of prior hospital admissions to the importance of caring behaviors. This also is consistent with the Cronin and Harrison (1988) study.

The subscale rankings suggest that certain minimum care requirements must be met before more affective aspects of care can be addressed. For example, the priority ranking of the Human Needs Assistance subscale reflects monitoring of

patient condition and technical skill. In contrast, the last ranked subscale, Expression of Positive/Negative Feelings, is a more affective, non physical aspect of caring. This is consistent with the hierarchy of human needs established by Maslow (1943). Watson (1979) adapted Maslow's (1943) hierarchy in establishing her theory of human care. Although Watson (1985) believes that each preceding carative factor contributes to the next and interacts to promote nursing care, the carative factors are not ranked by Watson (1985). Therefore, the rankings of CBA items and subscales in this research are not directly congruent to the carative factors in terms of hierarchal order. However, the findings of this research support Watson's (1985) theoretical framework with consistency between theoretical and study definitions.

Relationship of the Findings to the Theoretical Framework

Jean Watson's theory of human care (1985) served as the theoretical framework for this study. Watson (1985) believes that nursing goals are to help patients gain a higher degree of harmony within the mind, body, and soul. Further, Watson (1985) theorizes that a higher degree of harmony leads to self-knowledge and self-care processes. Watson (1985) believes her ten carative factors, used by the patient and nurse, will lead to a higher degree of harmony. She equates the ten carative factors to nursing interventions. Based upon Watson's (1985) attempts to understand how health, illness, and human behavior are interrelated, Cronin and Harrison

(1988) developed the CBA to further study caring in a critical care setting. Additionally, the 63 items of the CBA were categorized into seven subscales. The subscales are congruent with Watson's (1985) carative factors (Cronin & Harrison, 1988).

Watson (1985) views caring as a nursing term and as an outcome of scientific activity that represents the factors the nurse uses to deliver health care to the patient. The results of this research support Watson's (1985) view of caring. The most important indicators of caring were technical skills based on scientific knowledge (handling equipment, giving shots and treatments, knowing when to call the doctor, etc.). The CBA items and the subscales were ranked according to mean scores. In this study, the Human Needs Assistance subscale was ranked number one. The subscale included the four CBA items which were ranked most important. This subscale is comprised of behaviors reflecting the technical competency of the nurse. This subscale is congruent with Watson's (1985) carative factor of assistance with the gratification of human needs.

This research defined caring as "the process by which the nurse becomes responsive to another person as a unique individual, perceives the other's feelings, and sets that person apart from the ordinary" (Cronin & Harrison, 1988, p. 376). This definition is supported by the study results. The CBA items "treating the patient with respect" (CBA item 16),

"being kind and considerate" (CBA item 13), "knowing what they are doing" (CBA item 3), and "feeling that someone is there if needed" (CBA item 5) were among the top ten ranked CBA items. These items are included in the Humanism/Faith-Hope/Sensitivity subscale. The subscale had a mean of 4.31, ranking it third. The subscale is congruent with Watson's (1985) carative factors of: (a) the formation of a humanistic-altruistic system of values, (b) the installation of faith-hope, and (c) the cultivation of sensitivity to one's self and to others.

This research defined person as the patient who had undergone CABG and a second person as the nurse. According to Watson (1985), the person exists as a living, growing gestalt. Both patient and nurse were considered as "beings in the world" and were considered to have come together in a "caring occasion" (Watson, 1985). This concept is reflected through the Helping/Trust subscale. The mean for this subscale gave it a seventh place ranking. Four of the least important CBA items are part of this subscale. This reflects a lesser priority attributed to non physical needs than to the physical needs of human assistance. This subscale is congruent with Watson's (1985) carative factor of the development of a helping-trust relationship.

The research definition of environment was the CTSU in which the subject received care. This is consistent with Watson's conceptualization (1985) that environment is part of

a person's external world and includes external reality. The Supportive/Protective/Corrective Environment subscale mean was 4.20, ranking it fourth. This subscale is congruent with Watson's (1985) carative factor of the provision for a supportive, protective, and corrective mental, physical, sociocultural, and spiritual environment.

Watson (1985) believes that nursing goals are to help patients gain a higher degree of harmony which in turn generates self-knowledge and self-healing. The subscale of Teaching/Learning is reflective of this process. It was second in the subscale ranking. This finding supports Brown's (1982) study that concluded the patient's participation in a treatment plan is an indicator of care and enhances the patient's sense of worth and competence. The earlier findings of Watson, Burckhardt, Brown, Bloch, and Hester (1979) did not identify teaching as a high ranked component of caring. However, informal teaching through nurse-patient interactions was not specifically measured. Consideration must also be given to the evolution of the use of patient education from 1979 until this study. Patient education was previously a part of the medical model or provided through a formal education program. Patient education is now a routine function of the bedside nurse.

Nursing is viewed as a "human science of person and human health-illness experiences that are mediated by professional, personal, scientific, and ethical human care

transactions" (Watson, 1985, p.54). The link between gaining a higher degree of harmony and nursing is the nursing process. In this study, the 63 item CBA can be considered as representative of the nursing process. The CBA is a reflection of professional, personal, scientific, and ethical human care transactions that the nurse conveys to the patient.

Relationship of the Findings to Previous Studies

Theoretical Studies. Theoretical studies have centered around the conceptualization of caring and determining if caring can be reduced to behavioral tasks (Morse, Bottorff, Neander, & Solberg, 1991). Theorists have argued that caring is a moral ideal and is more than the competent performance of technical skills. Rather, caring is the nurse's attitude toward the patient (Brody, 1988). Other theorists are specific in stating nursing actions that are considered caring tasks (Brown, 1986; Orem, 1985). Morse, Bottorff, Neander and Solberg (1991) concluded that the concept remained underdeveloped and did not encompass all components of caring and clinical practice. Watson (1987) supports the idea of caring as a moral ideal without the exclusion of technical aspects as a reflection of caring.

The present research established technical skill by the nurse as the most important indicator of caring. The Human Needs Assistance subscale had a mean 4.63. However, the subscale did not reflect technical skill alone. Within the

subscale, the highest mean (4.92) was for CBA item 54, "knowing how to handle equipment". Also included in the subscale was CBA item 59, "help me feel like I have some control", with a mean of 4.52. This finding of technical competency (CBA item 54) and emotional needs (CBA item 59) within the same subscale is reflective of the debate that occurs throughout the literature: what is caring and can it be measured? Theorists who view caring as an affect believe that caring involves being with the patient rather than doing to the patient (Forrest, 1989). Morse, Bottorff, Neander, and Solberg (1991) concluded that theorists who support caring as a therapeutic intervention consider caring to be specific nursing actions. The findings of this research established affective behavior and technical skill as important perceptions of nurse caring behaviors. This suggests that caring involves both affective and technical behavior. This is consistent with Watson's (1987) view that caring is a moral ideal that includes technical aspects of care.

Empirical Studies. Caring behaviors have been studied in the outpatient and acute care setting. Outpatient setting studies revealed the importance of nursing behaviors, as indicators of caring, using different sample sizes, instruments, and study criteria. The findings of previous studies placed behavioral tasks and affective nursing behaviors (attributes) on the same plane of importance (Bowman, 1988; Brown, 1986; Hull, 1991; Larson, 1984; Mayer,

1987; Paternoster, 1988; Sloan, 1986). The results of this investigation revealed a greater importance attributed to behavioral tasks as an indicator of caring. Because this research was conducted in the acute care setting with a small sample size (n=25), it would be inappropriate to conclude that these findings differed from other studies. However, the findings in this study are consistent with the research of Cronin and Harrison (1988), which used and small sample size (n=22), and the research of Huggins, Gandy, and Kohut (1993) that used a large sample size (n=288). The research of Cronin and Harrison (1988) and Huggins, Gandy, and Kohut (1993) revealed technical competence as the most important indicator of caring. This would suggest that nursing behaviors have similarities that are common and able to be perceived as care indicators regardless of individual characteristics of either the patient or the nurse.

This study is a partial replication of a study by Cronin and Harrison (1988) who investigated the importance of nurse caring behaviors as perceived by 22 patients after myocardial infarction while in an acute care setting. The Cronin and Harrison (1988) study served as the seminal work for subsequent research. Cronin and Harrison (1988) found that nursing behaviors perceived as the most indicative of caring centers on the monitoring of patient condition and the demonstration of professional competence. The Cronin and Harrison (1988) results support those of Brown (1982), Larson

(1984), and Mayer (1986). Subsequent studies by Huggins, Gandy, and Kohut (1993) and Parsons, Kee, and Gray (1993) also reveal technical skill and competence of the nurse as the most important indicator of caring.

The nursing behaviors perceived as most indicative of caring in the present research also centers on the monitoring of patient condition and professional competence. This result supports the work of Cronin and Harrison (1988). It is noteworthy that CBA item 34, "teach me about my illness", was perceived as one of the most important nurse caring behaviors in the Cronin and Harrison (1988) study and was perceived of lesser importance in this study. CBA item 34 was ranked number 41 in this study as compared to number 9 in the Cronin and Harrison (1988) study. A possible explanation for this discrepancy could be the difference between MI and CABG patients with regard to physiological response. For example, both patient types experience the physical and emotional stress of an event. The body may respond to these stressors by an increased heart rate and blood pressure, dysrhythmias, or anxiety. Additionally, the CABG patient experiences the effects of general anesthesia, the bypass pump, and the demand of wound healing. Another consideration could be the difference in the population of the respective studies. In the Cronin and Harrison (1988) study, the population had an illness (MI) that had to "heal", whereas, the population in this study had surgery (CABG) and was "fixed".

The ranking of the subscales in this research, compared with the research by Cronin and Harrison (1988), suggests that caring behavior is congruent with a human need hierarchy. The priority of meeting physical needs is consistent in both studies. Differences in subscale rankings may be a reflection of the difference in perceived life threat (MI versus CABG).

This study was expected to demonstrate a relationship between demographic characteristics and caring behaviors. It was anticipated that males and females would view caring differently based upon socialization. Further, it was anticipated that subjects' number of prior hospital admissions would influence their perception of caring. It was the researcher's belief that those with a greater number of admissions would have a familiarity with the health care system which would influence their responses. Like the findings of Cronin and Harrison (1988), there were no significant relationships between demographic characteristics and caring behaviors.

Limitations and Recommendations

This study utilized a convenience sample. Limitations exist with convenience sampling because the subjects may be highly atypical of the population with regard to measured variables (Polit & Hungler, 1995). Because the subjects were relatively homogeneous in demographics, generalizability of the present study results is limited. Replication of this

study by random sampling and a larger sample would enhance the generalizability of the results.

The CBA was developed in 1988. Since 1988, the nursing profession and nursing care have undergone changes that may not be consistent with nursing care behaviors as identified on the CBA. Although the predetermined behaviors of the CBA are reflective of caring, they are not specific only to the nurse. The patients were asked an open ended question, "...what things did nurses say or do that made you feel cared for and about?". There were no responses to suggest that their comments were specific to the nurse. The instrument may be limited in its true reflection of nursing behavior, as other members of the health care team also perform those behaviors listed on the CBA. Further, the open ended question presents the opportunity for eliciting responses reflective of an affective domain. In contrast, the CBA is more reflective of a technical domain and these items were predetermined by Cronin and Harrison (1988).

Although the results of the present study were consistent with those of the Cronin and Harrison (1988) research, the mean scores of the CBA in this study were higher than those of the model study in both item importance and subscale ranking. This may reflect that study participants perceived that the focus was the care being received during the present hospitalization rather than a more global view of caring behaviors. This was evidenced by

the subjects' responses when approached for study participation. Subjects frequently commented that "they had received wonderful care at this hospital", "everyone here has taken such good care of me", or "this is the best care I have ever received". Although the study's purpose was reinforced with oral and written communication, it cannot be assumed that the subjects' responses on the CBA were more than an evaluation of their current admission. The serious nature of the subjects' current hospitalization (CABG surgery) was assumed to account for the value given to technical competence as the most important indicator of caring behavior.

The open ended question, "While in the CTSU, what things did nurses say or do that made you feel cared for and about?", was included to elicit a broader perspective of caring that may not be reflected on the CBA. Although this question was asked by the researcher to each subject, only five responded. It was assumed that the subjects' were not unwilling to answer, but rather were unable to formulate a response due either to pain medication or to a need for more time to process a response. Therefore, posing the question in an outpatient setting, with greater time between surgery and instrument application, may provide a higher response.

Implications for Nursing

According to Watson (1985), the goal of nursing is to help persons gain a higher degree of harmony of the mind,

body, and soul. The identification of nurse behaviors that the patient perceives as important indicators of caring provides the opportunity for the patient and nurse to come together in a caring occasion (Watson, 1985). Although caution is given to generalizability because of the small, homogeneous sample size, this study supports previous research and adds to the body of knowledge of caring behaviors. This study identifies the most important indicators of caring to be those behaviors that provide human needs assistance through technical knowledge. As nursing faces the reality of health care reform, and tasks once performed only by the professional nurse are frequently being performed by unlicensed personnel, it is essential to identify what the patient/consumer values and what can best be delivered by the nurse. Although other professions can be considered caring professions, caring is considered the essence of nursing (Leininger, 1977). If nursing is to distinguish itself from other caring professions and other health team members, caring must have empirical validation (Ben-Sira, 1990) that is specific to nursing and is congruent with patient/consumer priorities.

Although response to the open ended question was limited, the responses suggest that patients are able to identify the level of importance of caring. Continued research is needed to bridge the gap between theory and practice. Watson (1985) believes that nursing goals help

patients attain a higher degree of harmony of the mind, body, and soul. The nursing goals are implemented through interventions that are described as carative factors (Watson, 1985). The results of the Cronin and Harrison (1988) study established a link between theory and empirical validation through application of the CBA. Further, Cronin and Harrison established seven subscales, consisting of the CBA items, congruent with Watson's (1985) carative factors. The present study supports the results of the Cronin and Harrison (1988) study. The results of this study establish that the importance of caring can be measured and provide an additional link between theory and empirical data.

APPENDICES

APPENDIX A

Caring Behaviors Assessment

This instrument is used with the permission of the originators, Sherill Nones Cronin and Barbara Harrison. The completion and return of this instrument constitutes your consent to participate in this study.

CARING BEHAVIORS ASSESSMENT

Listed below are things nurses might do or say to make you feel cared for and about. Please decide how important each of these would be in making you feel cared for and about. For each item, indicate if it would be of:

Much Importance				Little Importance
5	4	3	2	1

Please circle the number that tells how important each item would be to you.

1. Treat me as an individual. 5 4 3 2 1

CARING BEHAVIORS ASSESSMENT

Much Importance					Little Importance
5	4	3	2	1	

2.	Try to see things from my point of view.	5	4	3	2	1
3.	Know what they're doing.	5	4	3	2	1
4.	Reassure me.	5	4	3	2	1
5.	Make me feel someone is there if I need them.	5	4	3	2	1
6.	Encourage me to believe in myself.	5	4	3	2	1
7.	Point out positive things about me and my condition.	5	4	3	2	1
8.	Praise my efforts.	5	4	3	2	1
9.	Understand me.	5	4	3	2	1
10.	Ask me how I like things done.	5	4	3	2	1
11.	Accept me the way I am.	5	4	3	2	1
12.	Be sensitive to my feeling and moods.	5	4	3	2	1
13.	Be kind and considerate.	5	4	3	2	1
14.	Know when I've "had enough" and act accordingly (for example, limiting visitors)	5	4	3	2	1
15.	Maintain a calm manner.	5	4	3	2	1
16.	Treat me with respect.	5	4	3	2	1
17.	Really listen to me when I talk.	5	4	3	2	1
18.	Accept my feelings without judging them.	5	4	3	2	1

CARING BEHAVIORS ASSESSMENT

Much Importance						Little Importance
	5	4	3	2	1	
19.	Come into my room just to check on me.	5	4	3	2	1
20.	Talk to me about my life outside the hospital.	5	4	3	2	1
21.	Ask me what I like to be called.	5	4	3	2	1
22.	Introduce themselves to me.	5	4	3	2	1
23.	Answer quickly when I call for them.	5	4	3	2	1
24.	Give me their full attention when with me.	5	4	3	2	1
25.	Visit me if I move to another hospital unit.	5	4	3	2	1
26.	Touch me when I need it for comfort.	5	4	3	2	1
27.	Do what they say they will do.	5	4	3	2	1
28.	Encourage me to talk about how I feel.	5	4	3	2	1
29.	Don't become upset when I'm angry.	5	4	3	2	1
30.	Help me understand my feelings.	5	4	3	2	1
31.	Don't give up on me when I'm difficult to get along with.	5	4	3	2	1
32.	Encourage me to ask questions about my illness and treatment.	5	4	3	2	1
33.	Answer my questions clearly.	5	4	3	2	1

CARING BEHAVIORS ASSESSMENT

Much Importance				Little Importance
5	4	3	2	1

34.	Teach me about my illness.	5	4	3	2	1
35.	Ask me questions to be sure I understand.	5	4	3	2	1
36.	Ask me what I want to know about my health/illness.	5	4	3	2	1
37.	Help me set realistic goals for my health.	5	4	3	2	1
38.	Help me plan ways to meet those goals.	5	4	3	2	1
39.	Help me plan for my discharge from the hospital.	5	4	3	2	1
40.	Tell me what to expect during the day.	5	4	3	2	1
41.	Understand when I need to be alone.	5	4	3	2	1
42.	Offer things (position changes, blankets, back rub, lighting, etc.) to make me more comfortable.	5	4	3	2	1
43.	Leave my room neat after working with me.	5	4	3	2	1
44.	Explain safety precautions to me and my family.	5	4	3	2	1
45.	Give my pain medication when I need it.	5	4	3	2	1
46.	Encourage me to do what I can for myself.	5	4	3	2	1

CARING BEHAVIORS ASSESSMENT

	Much Importance				Little Importance
	5	4	3	2	1
47.	Respect my modesty (for example, keeping me covered).	5	4	3	2	1
48.	Check with me before leaving the room to be sure I have everything I need within reach.	5	4	3	2	1
49.	Consider my spiritual needs.	5	4	3	2	1
50.	Are gentle with me.	5	4	3	2	1
51.	Are cheerful.	5	4	3	2	1
52.	Help me with my care until I'm able to do it for myself.	5	4	3	2	1
53.	Know how to give shots, IVs, etc.	5	4	3	2	1
54.	Know how to handle equipment (for example, monitors).	5	4	3	2	1
55.	Give my treatments and medications on time.	5	4	3	2	1
56.	Keep my family informed of my progress.	5	4	3	2	1
57.	Let my family visit as much as possible.	5	4	3	2	1
58.	Check my condition very closely.	5	4	3	2	1
59.	Help me feel like I have some control.	5	4	3	2	1

CARING BEHAVIORS ASSESSMENT

Much Importance				Little Importance
5	4	3	2	1

60.	Know when it's necessary to call the doctor.	5	4	3	2	1
61.	Seem to know how I feel.	5	4	3	2	1
62.	Help me see that my past experiences are important.	5	4	3	2	1
63.	Help me feel good about myself.	5	4	3	2	1

APPENDIX B

Personal Data Sheet

ID#_____

PERSONAL DATA SHEET

The completion and return of this data sheet constitutes your consent to participate in this study.

Date:_____

1. How old are you?_____

2. What is your highest level of education?

_____ 1. Less than high school graduate

_____ 2. High school graduate

_____ 3. Technical/college classes

_____ 4. Graduate from college

_____ 5. Some master's classes

_____ 6. Master's, Ph.D graduate

3. _____ 1.Male _____ 2.Female

4. Current Marital Status (Please check)

_____ 1. Never been married

_____ 2. Divorced

_____ 3. Widowed

_____ 4. Currently Married

5. Annual Income Level (Please check)

_____ 1. $ 0 - 20,000.

_____ 2. $ 21,000 - 40,000.

_____ 3. $ 41,000 - 60,000.

_____ 4. $ 61,000 - 80,000.

_____ 5. $ Greater than $80,000.

6. How many times have you been hospitalized in the past year, not counting this admission?

_____ 1. 0

_____ 2. 1-5

_____ 3. 6-10

_____ 4. Greater than 10

Do Not Complete This Portion

Verbatim answer to the question, "While in the CTSU, what things did nurses say or do that made you feel cared for and about?"

APPENDIX C

Written Confirmation of Verbal Script

WRITTEN CONFIRMATION OF VERBAL SCRIPT

My name is Susan Tuttle and I am a registered nurse. I am currently a graduate nursing student at Grand Valley State University. As part of the requirement for my masters degree I am conducting a study on caring behaviors.

I am studying what nursing behaviors are interpreted by the patient who has had coronary artery bypass grafting surgery as the most and least important indicators of caring. I would appreciate your participation in this study.

Your agreement to participate will involve completing a personal data sheet that allows me to know a little bit about you. It also involves the completion of a 63 item questionnaire. The questionnaire lists a variety of activities that you will be asked to rank as to their importance to you.

The completion of this data sheet and questionnaire will be done once you have been discharged from the hospital. I would request that this be returned to me within two weeks of your discharge. I will provide to you a self addressed stamped envelope to mail the completed documents to me.

Your participation is strictly voluntary. If you decide to participate or not to participate will have no influence on the care you receive during your hospitalization. There are no risks for you by participating in this study. Your answers will be kept confidential and all documents will be coded by number. There will be no identification of you by name.

I would like to thank you for agreeing to participate in this study. The information obtained is important in identifying what nursing behaviors are important to you as a patient. Please feel free to contact me if you have questions.

Susan Tuttle
3645 Holiday Village Road
Traverse City, MI 49686
(616) 938-1517

APPENDIX D

Caring Behaviors Assessment Ranking with Mean

CARING BEHAVIORS ASSESSMENT RANKING WITH MEAN

1.	CBA 54	4.92
2.	CBA 53	4.92
3.	CBA 60	4.84
4.	CBA 55	4.84
5.	CBA 33	4.84
6.	CBA 3	4.84
7.	CBA 45	4.80
8.	CBA 5	4.68
9.	CBA 16	4.64
10.	CBA 13	4.64
11.	CBA 27	4.64
12.	CBA 48	4.60
13.	CBA 58	4.56
14.	CBA 37	4.52
15.	CBA 17	4.52
16.	CBA 12	4.52
17.	CBA 59	4.52
18.	CBA 15	4.48
19.	CBA 14	4.48
20.	CBA 52	4.44
21.	CBA 38	4.44
22.	CBA 24	4.44

CARING BEHAVIORS ASSESSMENT RANKING WITH MEAN

23. CBA 23	4.44
24. CBA 11	4.40
25. CBA 56	4.40
26. CBA 44	4.40
27. CBA 39	4.40
28. CBA 32	4.40
29. CBA 1	4.40
30. CBA 4	4.36
31. CBA 36	4.36
32. CBA 35	4.36
33. CBA 61	4.36
34. CBA 40	4.36
35. CBA 47	4.32
36. CBA 46	4.32
37. CBA 18	4.28
38. CBA 19	4.28
39. CBA 31	4.24
40. CBA 57	4.20
41. CBA 34	4.20
42. CBA 29	4.20
43. CBA 10	4.16
44. CBA 9	4.08
45. CBA 43	4.04
46. CBA 22	4.00
47. CBA 28	4.00

CARING BEHAVIORS ASSESSMENT RANKING WITH MEAN

48. CBA 51	3.96
49. CBA 30	3.96
50. CBA 41	3.96
51. CBA 7	3.96
52. CBA 42	3.92
53. CBA 8	3.84
54. CBA 2	3.84
55. CBA 62	3.80
56. CBA 63	3.80
57. CBA 50	3.80
58. CBA 6	3.72
59. CBA 49	3.28
60. CBA 21	3.24
61. CBA 26	3.20
62. CBA 20	3.08
63. CBA 25	2.48

Note: Mean scores were rounded to two decimal points from original computer printout that extended past the two points. This accounts for the ranking or mean scores that have the same numerical value

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