



ICU patients and ICU nurses perceptions of important nurse caring behaviors
by Gretchen Torrence Vanek

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

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Abstract:

This research investigated perceptions of important nurse caring behaviors by utilizing the Q-sort instrument (CARE-Q) developed by Larson (1981). Participants included 25 angioplasty/ICU patients and 25 ICU nurses. The intent was to determine whether or not these two groups would assign the same degree of importance to nurse caring behaviors. The patients had all undergone elective angioplasty procedures and were admitted to the ICU for at least 18 hours. Methodology for completing the Q-sort instrument consisted of sorting 50 cards containing nurse caring behaviors into seven pockets ranging from most important to least important. The mean scores for the 50 items were ranked in chronological order for each group.

The data revealed that the highest mean scores for angioplasty/ICU patients and ICU nurses consisted primarily of behaviors related to the nurses' physical care and accessibility. The two groups had seven identical items in the highest mean scores. The patient group (N = 57) of Larson's study revealed the same themes in the highest mean score items and six were identical. The highest mean score item, "Knows how to give shots, I.V.s, etc....," was the same for the patient groups of both studies. The nurse groups of the two studies had six identical items in the highest mean scores, although the primary themes for Larson's sample were not in agreement with the nurses of this study. Data indicated that angioplasty/ICU patients and ICU nurses agreed on a majority of the behaviors perceived as most important to caring. There was closer agreement between the patients and nurses of this study than between the groups of Larson's study.

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APPROVAL

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This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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ABSTRACT

This research investigated perceptions of important nurse caring behaviors by utilizing the Q-sort instrument (CARE-Q) developed by Larson (1981). Participants included 25 angioplasty/ICU patients and 25 ICU nurses. The intent was to determine whether or not these two groups would assign the same degree of importance to nurse caring behaviors. The patients had all undergone elective angioplasty procedures and were admitted to the ICU for at least 18 hours. Methodology for completing the Q-sort instrument consisted of sorting 50 cards containing nurse caring behaviors into seven pockets ranging from most important to least important. The mean scores for the 50 items were ranked in chronological order for each group. The data revealed that the highest mean scores for angioplasty/ICU patients and ICU nurses consisted primarily of behaviors related to the nurses' physical care and accessibility. The two groups had seven identical items in the highest mean scores. The patient group (N = 57) of Larson's study revealed the same themes in the highest mean score items and six were identical. The highest mean score item, "Knows how to give shots, I.V.s, etc.....," was the same for the patient groups of both studies. The nurse groups of the two studies had six identical items in the highest mean scores, although the primary themes for Larson's sample were not in agreement with the nurses of this study. Data indicated that angioplasty/ICU patients and ICU nurses agreed on a majority of the behaviors perceived as most important to caring. There was closer agreement between the patients and nurses of this study than between the groups of Larson's study.

CHAPTER I

INTRODUCTION

Problem

Rapid progress in medical therapy and technology for patients with life-threatening illness has been matched by the advancement of nursing practice in the intensive care unit (ICU). For example, ICU nurses now monitor the delicate titration of potent cardio-vascular drugs, manage life-sustaining machinery, and utilize decision-making processes to solve complex problems inherent in these treatment modalities. This expanded role has increased the concern that the humanitarian needs of the patient in ICU are obscured by the technological adjuncts. Stronger conceptual models are needed to assure that the total needs of the patient are met. The concept of caring represents an advancement in the organization and delivery of holistic care to critically ill patients.

In 1981, Larson developed a Q-sort instrument (CARE-Q) to test the emerging concept of caring. She identified 50 nurse caring behaviors, using the Delphi method, under the scales of (a) Accessible, (b) Explains and Facilitates, (c) Comforts, (d) Anticipates, (e) Trusting Relationship, and (f) Monitors and Follows Through. Larson then tested

the perceived importance of the behaviors using oncology patients and nurses. The results of her study indicated significantly divergent perceptions between the two groups. For example, in the multivariate analysis performed to compare the patient and nurse samples regarding the six scales, Larson found that patients (N = 57) assigned greater importance to behaviors under the Monitors and Follows Through scale, while nurses (N = 57) ascribed the most value to behaviors under Comforts and Trusting Relationship scales (see Appendix J). Also, the highest mean score item among the patient population was "Knows how to give shots, IVs, etc., and how to manage the equipment like IVs, suction machines, etc." ($\bar{M}$ = 5.0350); the nurse sample had "Listens to the patient" as the highest mean score item ($\bar{M}$ = 5.8596). The patients ranked behaviors in the physical domain the highest, while the nurses perceived caring in the psychological domain as most important.

Patients with recent ICU experience and ICU nurses were selected as the focus of this study. The author wanted to determine whether there was greater agreement between these two groups regarding the ranking by importance of nurse caring behaviors in the physical domain than between groups that have been studied outside the ICU. Patients in the ICU have an increased possibility of dying suddenly; they suffer severe physiologic threat which requires close observation and rapid accurate treatment. Their physical,

rather than emotional, well-being is uppermost in their minds and is dealt with by the performance of many technical skills. Additionally, ICU nurses have more exposure to their patients because the nurse-patient ratio is rarely greater than 1:2. There are numerous physical activities that involve almost constant attention at the bedside. The specialized knowledge and experience of ICU nurses justify their focus on the physical needs of their patients. While the "body-mind-spirit" (Kenner, Guzzetta, & Dossey, 1981) concept of patient caring is desirable, the numerous needs of ICU patients demand that the nurses prioritize the activities they perform. When a choice must be made, emotional well-being is sacrificed for the survival of the body. Therefore, the problem for this study was to determine whether or not ICU patients who have undergone elective angioplasty, and ICU nurses, assign the same degree of importance to nurse caring behaviors.

Purpose and Research Questions

The purpose of this study was to describe the similarities and differences in the perceptions of angioplasty patients who have had recent ICU experience and ICU nurses concerning the rank value of nurse caring behaviors.

The following research questions were addressed: (1)
What nurse caring behaviors are perceived as most important

by the angioplasty/ICU patients and ICU nurses? (2) What nurse caring behaviors are perceived as least important by the angioplasty/ICU patients and ICU nurses? (3) Do similarities exist between the results of this study and Larson's (1981) study? (4) Do the angioplasty/ICU patients and ICU nurses in this study have more commonality on the highest and lowest nurse caring behaviors than the patients and nurses in Larson's study?

Definitions

The following definitions were assembled in order to provide continuity to the present study.

"Nurse caring behaviors: The acts, conduct, and mannerisms enacted by professional nurses which convey to the patient concern, safety and attention" (Larson, 1981, p. 4). This definition was operationalized using the Care Assessment Evaluation Q-sort (CARE-Q), an instrument developed by Larson (1981) that consisted of 50 cards describing 50 caring behaviors that nurses enact.

Intensive care unit (ICU): A section of the hospital containing specialized personnel and equipment for continuous monitoring and interventions. The nurse-patient ratio is no greater than 1:2.

ICU nurses: Professional nurses (RNs) who practice in the ICU.

Angioplasty/ICU patients: People over 21 years of age who have undergone percutaneous transluminal coronary angioplasty (PTCA), who have spent at least 18 hours in the ICU after the procedure, and who have remained alert and oriented during the ICU stay.

Percutaneous transluminal coronary angioplasty (PTCA): Definitive therapy for select patients suffering coronary artery disease. A balloon-tipped catheter is advanced from the femoral artery up into stenosed coronary arteries. The balloon is inflated to compress the atheromatous plaque, thereby re-establishing lumen patency. Arterial rupture, thrombosis, or myocardial infarction are some complications that may occur. After the procedure, admission to the ICU is required to detect and treat potentially lethal complications (Gershan & Jiricka, 1984). The procedure can be performed on an elective or emergency basis. Only patients having elective PTCAs were considered for this study.

Assumptions of the Study

This study was based on the following assumptions:

1. The items of the CARE-Q instrument are accepted by all subjects of the study as nurse caring behaviors.
2. The six scales of the CARE-Q may not be all inclusive of the characteristics of nurse caring behaviors (Larson, 1981).

CHAPTER II

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Introduction

The essays by Gaut (1979, 1983) formed the conceptual framework for this study. Gaut, using conceptual, semantic, and philosophical analysis, explicated terms and conditions that clarify the concept of caring. Further focusing of this concept on the nursing discipline offers structured and consistent methods of researching, teaching, and practicing those behaviors which will ultimately be perceived by patients as "caring."

Evolution of the Concept of Caring in Nursing

The development of the concept of caring has progressed rapidly over the past decade. Theorists such as Leininger (1977) and Watson (1979) initiated descriptions of caring that encompass behavioral and attitudinal aspects, as well as processes of caring relationship. While most of the writings of the early proponents of caring were fairly abstract and general in their exploration (Leininger, 1981; Gaut, 1979), certain commonalities emerged which are valued tenets to those now investigating the concept. First, caring is the very core of nursing practice (Gaut, 1983;

Larson, 1981; Leininger, 1977; Watson, 1979). Since 1965, the American Nurses Association (ANA) has inculcated the concept of caring into its policy statements regarding the scope and framework of nursing practice. The 1980 Social Policy Statement states, "Nurses are guided by a humanistic philosophy having caring coupled with understanding and purpose as its central feature" (ANA, p. 18).

Second, caring is "a way of being coupled with a way of doing" (Brown, 1981, p. 58). That is, certain attitudes must accompany certain behaviors in order to fulfill the criteria for caring. This theme directly repudiates a historical definition of caring that characterized nursing care as physical tasks to meet the needs of patients; attitudinal qualities were mentioned as important, but not integrated into the description (Brown, 1981; Gaut, 1983; Leininger, 1981).

Third, caring is directed toward another. It is an interpersonal process which is not complete without a recipient for the caring (Brown, 1981; Gaut, 1983, Larson, 1981).

Fourth, caring is goal-directed, and the caring agent and recipient are both involved in the goal-planning and evaluation of the outcome (Brown, 1981; Larson, 1981).

Fifth, the outcome must result in positive change for the recipient of the caring (Gaut, 1983).

The Concept of Caring Advanced by Gaut

The analytical work by Gaut (1983) proceeded from these five common principles of the earlier theorists, albeit not explicitly. Because the concept of caring was laden with multiple definitions, Gaut employed semantic analysis to determine the senses of caring. First, she examined the uses of care/caring, and discriminated between the definitions of the noun and verb/participle forms. She found that three general definitions encompass common usage: (a) attention to or concern for; (b) responsibility for or providing for; and (c) regard, fondness, or attachment (p. 315). The scholarly writings explored by Gaut support the general definitions in common usage (p. 315).

When used as a noun, care is a thing, stable and without energy. The word care requires a referent to give it meaning, such as, "care is interest" (Gaut, 1983, p. 315). The participle form, caring, which is also context dependent, adds action and purpose to the description. Gaut chose this form in order to include processes as well as context. The actions that denote caring can be general, or specific, and occur over time. Caring, therefore, relies on the action, the intention of the carer, the recipient of the caring, and the circumstances to give it full definition.

From this semantic analysis, Gaut derived a

philosophical formula to evaluate the components of caring: "What must be true to say that S is caring for X?" (Gaut, 1983, p. 317). The symbols S and X will accept any number of variables, but Gaut does not explicitly name any. However, from the use of the formula, it can be ascertained that S is any nurse and X is any patient.

Through explication of the concept of caring, Gaut (1983) concluded that five conditions must be met for caring to occur: (a) S must be aware, directly or indirectly, of the need for care in X; (b) S must know that certain things can be enacted to improve the situation; (c) S must intend to do something for X; (d) S must specifically choose and carry out an activity intended to create positive change in X; and (e) positive change in X is a result of enacting what is good for X rather than any other X (p. 319). Additionally, Gaut asked extenuating questions to further clarify the stated conditions. First, "In what sense must S be aware of X in order to care for X" (p. 318)? Gaut determined that conscious attention of S toward X as a unique individual fulfills the formula. This process includes awareness through self to X. Respect, described as consideration for or regard for another person (p. 320), is a corollary to awareness. Because rational exchange of ideas is mediated by respect for the other person, it is an essential attitude for S if caring is to occur (p. 320).

Second, "What must S know in order to care for X" (Gaut, 1983, p. 318)? The explication of this question led Gaut to combine the first two conditions, as the knowledge S must have includes a perception of X as an individual. S must also be able to identify the need for care in X, and choose the appropriate response.

Third, "What is the relationship between the intended action, and the need for care" (Gaut, 1983, p. 318)? This question binds the third and fourth conditions into one, as S cannot be caring for X if the action chosen and implemented is not intended to do something for X. The particular need for care influences the implementation of action.

Fourth, "What could count as a positive change of direction for X" (Gaut, 1983, p. 318)? Positive change implies movement toward what is perceived as good. This demands judgment on the part of S as to what the need of X is in a certain situation. Gaut emphasizes that this judgment is the sole determinant of whether the action will lead to positive change (p. 322).

In the final analysis of the components of caring by Gaut (1983), the need for care by X is the common theme for the finished three conditions:

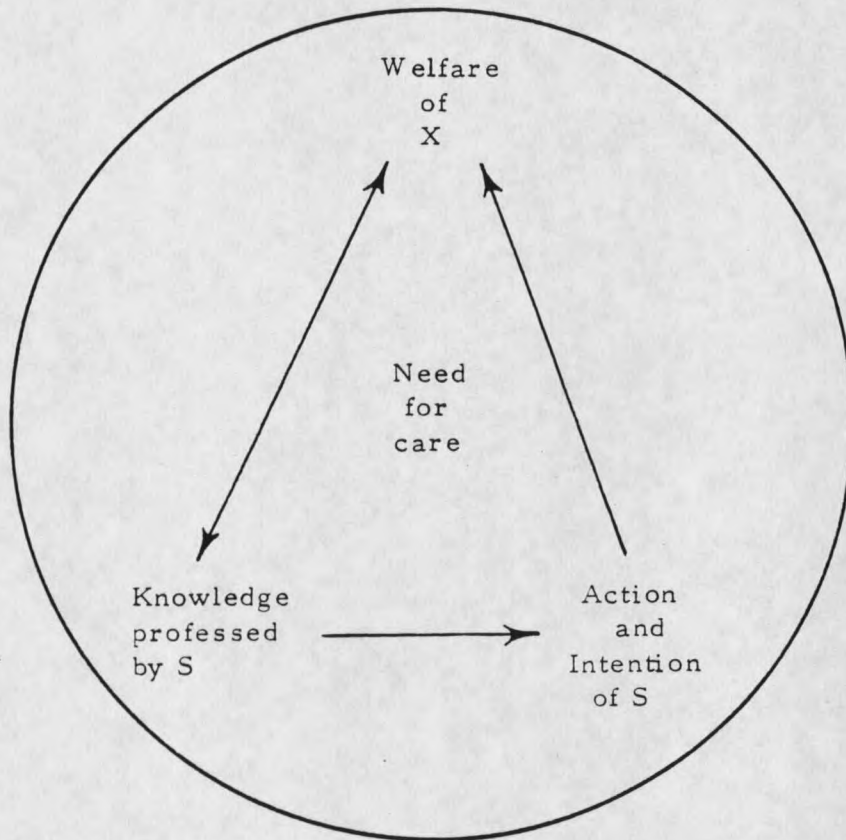
- (a) S must have knowledge about X to identify a need for care, and must know that certain things could be done to improve the situation; (b) S must choose and implement an action based on that knowledge and intend the action as a means for bringing about a positive change in X; (c) the positive change condition must be

judged solely on the basis of a "welfare-of-X" criterion. (p. 322).

Figure 1 depicts the model demonstrating caring according to Gaut's (1983) theory. The need for care creates the environment within which S, the nurse, enacts caring on X, the patient. The welfare of X is paramount and therefore at the top of the triangle. S possesses special didactic and experiential knowledge of the needs created by disruptive processes. Additionally, S must use knowledge to gain information from X about needs particular to this X. For this reason the left arm of the triangle is bidirectional. All knowledge available to S is directed toward formulating the intention and action for fulfilling the needs of X. Finally, the caring enacted by S toward X must enhance the welfare of X, so the right arm of the triangle is unidirectional. The comments below the model refer to the above conditions.

The conceptual framework by Gaut has extended and refined those components of caring that have endured among nursing theorists. Testing and application of this concept of caring can be more concise and objective, increasing its integration into nursing practice. The following sections will examine the application of Gaut's concept of caring to the CARE-Q Q-sort (Larson, 1981) used in this study, and to caring in the ICU.

ENVIRONMENT



1. S must have knowledge about the need for care ($\downarrow$) by X. Knowledge is equally as important as the action in achieving the welfare of X.
2. Knowledge is equally as important as action in achieving the welfare of X ($\uparrow\uparrow$).
3. Knowledge is utilized to decide the intention and action to be enacted toward X ($\longrightarrow$).

Figure 1: Vanek's model of Gaut's (1983) theory.

The CARE-Q Related to the Concept of Caring

In a discussion of the qualities of a Q-sort as a research tool, Kerlinger (1973) emphasized that the items of a Q-sort must be within the framework of a unifying concept. This ensures that measurement involved items with a common theme, not "apples and oranges." The CARE-Q developed by Larson (1981) shows strong adherence to the concept of caring when tested against Gaut's conditions. If the 50 CARE-Q items within the six scales (see Appendix J) are substituted into the formula "What must be true to say that S is caring for X," the items represent various actions for S. For instance, if the CARE-Q item "listens to the patient" is substituted into the formula, it reads: "listens to the patient" must be true to say that S is caring for X.

The need for care by X, the common element of the three conditions proposed by Gaut (1983), is the basis for perceptions obtained with the use of the CARE-Q. That is, X sanctions the caring action if it fulfills a need. The perceived importance, by X, of the need for care dictates the importance of the caring action to X. The CARE-Q measures the importance and experience that justify perceptions of need for care by X, and what activities fulfill the need. The CARE-Q investigates caring actions, as perceived by X and S.

Since the welfare of X must be achieved for the

conditions of caring to be fulfilled, the goal proposed by Larson (1981), that X "feel cared for" (p. 4) is valid within the framework of caring by Gaut. This does not assume that X is consciously alert for a causal relationship between actions by S and simultaneous positive change. Indeed, many caring actions are performed by S with the intention of avoiding the attention of X. Efforts to provide privacy or sleep for X are examples. However, it does assume that X, faced with prioritizing 50 written caring activities, will draw on perceptions formed from experiencing caring enacted by S.

Caring in the ICU

The ICU Environment

Larson (1981) introduced the concept of a "captive environment" to describe a component of the nurse-patient relationship within the hospital setting. That is, there is little choice for patients or nurses as to who they interact with once they have entered the hospital boundaries (p. 13). However, the ICU is a stronger captive environment than the general hospital unit. First, entry into the ICU is necessitated by life-threatening disease or injury, or potentially lethal complications of treatment. Second, patients also relinquish control of their surroundings and privacy. Few personal items are allowed in the ICU. Even flowers from significant others may be given to family 15

members to keep. Third, patients are physically attached to a varying number of tubes and wires which restrict mobility. Oxygen administration, electrocardiograph monitoring, and invasive hemodynamic monitoring are some of the bonds that hold patients captive even as they serve life-saving functions. Finally, patients' visits with significant others are restricted in frequency and duration, compounding the sense of isolation. It is ironic that the things necessary to save patients also make them captives of the ICU. The caring that nurses provide ICU patients is important in off-setting this negative sense.

The nurse-patient relationship. The nurse-patient relationship has the greatest potential for counterbalancing the negative effects of the captive environment. It is the most consistent factor of the ICU experience. The nurses are in close proximity to their patients 24 hours a day. They manage the entry of other health care members into the patients' environment. Even visitation by significant others is controlled, to a large degree, by the nurses.

These responsibilities that ICU nurses assume for their patients make caring a quality of paramount importance. Conditions for caring proposed by Gaut (1983) are readily applicable to the nurse-patient relationship in this speciality area. First, the nurse caring behaviors enacted are based on scientific knowledge.

The smaller ratio of nurses to patients, 1:1 or 1:2, allows frequent observation and measurement of physiologic parameters. Advanced technology, such as hemodynamic monitoring, yields a wealth of objective data for evaluation. Because physiologic needs must be met quickly in the ICU, judgement and problem-solving skills are continually challenged. Therefore, implementation of caring activities resulting in positive change, the second of Gaut's conditions, can be noted in a single eight-hour shift. The third condition, the welfare of X, is shown by the awareness and intention of ICU nurses. For instance, control of a ventricular arrhythmia with an intravenous injection of Lidocaine can proceed so smoothly that the patient is unaware that the problem occurred. Besides identifying the arrhythmia, knowing the treatment, and enacting the treatment, the patient's responses to the situation are considered. Is the patient aware that something is wrong, or is he asleep? Are explanation and reassurance needed, or silent intervention? All considerations of how activities can be caring are based on the total needs of the patient.

The focus of caring for angioplasty/ICU patients and ICU nurses consists of activities in the physical domain. Psychosocial behaviors provide supplementary and/or complementary caring to enhance the positive outcomes of the skills performed.

Literature Review

Research within the framework of caring has only evolved over the last decade. Linn (1975) surveyed the "care-cure attitudes" (p. 145) of medical faculty (N = 77) and students (N = 112), and nursing faculty (N = 27) and students (N = 135). Using a Likert-type questionnaire, Linn asked subjects to respond by agreeing or disagreeing with statements concerning the importance of caring versus curing. All the groups were found to rate "care" as an important component of medical and nursing therapy, although the nurse groups valued it somewhat more than the medical groups. Also in 1975, Henry looked at the perceptions of home patients (N = 50) concerning the behaviors of public health nurses that indicated caring. Using an open interview guide, subject responses were gathered under the headings of what the nurse does. The author concluded that good interpersonal and technical skills were perceived as caring by subjects in this study. Another study of patients' perceptions of nursing care was conducted in 1976 by Kirchoff. Patients (N = 11) who had been hospitalized in the pulmonary intensive care unit (PICU) were asked multiple-choice questions about the care they recieved. Four open-ended questions explored events that were stressful, and how they were resolved. The results of the study indicated that 6 of the 11 patients had definite perceptions of the care they had received, and

whether the care received was caring behavior. These subjects had varying numbers of negative responses expressing omissions in care. Although the sample was quite small, the results of the study were communicated to the PICU nurses. While the perceptions of the staff were not studied systematically, the author stated, "The nurses also had perceived these problem areas and were already in various stages of correcting these deficiencies. The patients and nurses agreed!" (p. 39).

This early research in caring set the stage for more structured studies a few years later. In 1981, Ford followed in the steps of Linn by studying perceptions of caring in nurses. Clinical nurses (N = 20), educators (N = 45), and non-practicing nurses (N = 16), were asked open-ended questions about caring. Two attributes of caring that were common to all three groups were concern for the welfare of patients and giving of self. The only caring behavior that all three groups mentioned was listening, although helping and showing respect were categories that educators and practicing nurses favored. Brown (1981) focused on hospitalized patients (N = 80) to gain perceptions of nursing behaviors that are caring. An open-ended interview and Likert-type questionnaire addressed nursing behaviors, both the task and emotional dimensions. The results of the data analysis showed that caring is a result of (a) what and how the nurse does and

(b) what the nurse is like. This study supported the common belief that caring is a way of doing and being.

More in-depth research into the nurse-patient relationship was conducted by Gardner and Wheeler (1981). Using interview and questionnaire methods, they attempted to measure 67 nursing behaviors considered supportive. These authors considered support to be "a specific component of the caring process" (p. 69). They studied nurses (N = 79) and patients (N = 119) from the medical, surgical, and psychiatric departments of one hospital. They found no statistical significance among the nurse subjects in the differing specialty areas; there was identical agreement in three of the ten most important items with the patients. Both groups agreed that showing interest, assessing, and providing moral support were among the most important supportive behaviors enacted by nurses. There was disagreement between the two groups on 35% of the behaviors. Patients valued competent and timely physical care, and friendliness more than the nurses. Nurses indicated that listening and discussing patients's feelings were more important.

Larson (1981) explored the perceptions of oncology patients (N = 57) and nurses (N = 57) who interacted with onocology patients, using a Q-sort to measure responses. Larson developed the Q-sort, called CARE-Q, through a complex Delphi procedure in order to define, as precisely

as possible, caring behaviors that nurses enact toward patients. The results of the study paralleled those of Gardner and Wheeler (1981) in several ways. First, 5 of the 10 most important caring behaviors, out of a total of 50, were identical for both groups. These findings seem to indicate, as did Gardner's and Wheeler's study, that some of the caring behaviors considered important by nurses are also perceived by patients as important. Second, both studies showed statistically significant differences between nurses and patients. In Larson's study, nurses gave higher priority to behaviors related to Comfort and Trusting scales, while patients identified Monitoring and Follow Through items as most important to them (see Appendix K). Third, the items that the patients considered most important, as in Gardner's and Wheeler's study, related to skill competence and physical care.

Summary

The evolution of nursing theory pertaining to caring has produced five major assumptions:

1. Caring is the core of nursing practice;
2. Caring consists of both attitudes and behaviors;
3. Caring is an interpersonal process directed from one person to another;
4. Caring is goal-directed;
5. Caring must result in a positive outcome.

Based on these tenents, Gaut (1983) derived a philosophical question appropriate for structuring and evaluating research and clinical caring.

Research in caring revealed ideas about the relative importance of physical and psychosocial activities. Linn's study (1975) dealt with the "care-cure attitudes" of physicians and nurses. "Care" denoted the psychosocial domain, while "cure" represented the physical domain. Both groups ascribed importance to caring, although less by the physicans than the nurses. Henry (1975) and Brown (1981) asked home and hospitalized patients what they perceived as caring by nurses. The responses included both technical and interpersonal skills. Nurse subjects considered caring to be given of self and concern for patient welfare in Ford's 1981 study. Larson (1981) and Gardner and Wheeler (1981) found that their nurse subjects perceived caring activities in the psychosocial domain to be more significant than those in the physical domain. However, the patient subjects in studies significantly valued physical activities in caring more than the psychosocial.

Research to date indicated a division between the physical and humanistic aspects of caring, while theory advocated unity of the two domains. More investigation into all aspects of caring is needed to resolve the dichotomy and advance an integrated concept.

CHAPTER III

METHODOLOGY

SampleGeneral Description

The samples for this study were drawn from the ICU of St. Patrick Hospital, Missoula, Montana. The ICU was a 14-bed combination surgical, medical, and coronary intensive care unit, consisting of single bed rooms. The nurses wore scrub outfits and no caps. Name tags identified them as professional nurses. The nurses were assigned primary care of 1 or 2 patients, depending on the severity of each patient's condition. Patients who had PTCA's comprised the largest single group treated in the ICU.

The interactions between ICU nurses and post-PTCA patients were frequent and intense. Because the procedure was done under local anesthesia, patients were awake the whole time. Upon admission to the ICU following PTCA, they exhibited varying degrees of anxiety pertaining to the possible complications of vessel closure, arrhythmias, cardiac tamponade, congestive heart failure, and/or myocardial infarction (Gershan & Jiricka, 1984). The other stressors of the ICU environment also applied to PTCA

patients. For example, femoral arterial and venous cannulation restricted their mobility, so that even turning in bed required assistance. Hemodynamic parameters, vital signs, and cardiac rhythm were assessed every 15 minutes initially, or more frequently if physical stability was not assured. therefore, interventions related to psychosocial support, physical comfort, and medical therapy all required the presence of the nurse at the patient's bedside. By the time patients were transferred from the ICU to the cardiac unit, they had encountered a broad range of caring behaviors from ICU nurses.

Criteria for Sample Selection

Patient criteria. To be considered for selection as a subject, patients had to fulfill the following criteria:

1. Elective angioplasty was performed without complication;
2. Their ICU stay was 18 to 72 hours;
3. They were alert and oriented during the ICU stay;
4. They were medically stable after transfer from ICU.

Nurse criteria. the ICU nurses were considered for selection as subjects if the following requirements were fulfilled:

1. They were registered nurses;
2. They had to have worked in the ICU for one year or more.

Sampling Procedure

Patient sample. Patients fulfilling the basic criteria were approached within eight hours after their transfer from ICU, so the experience was still fresh. The primary care nurses screened the potential candidates for mental alertness and physical stability. When the investigator met the patients, they were told that the study was to find out what nurses in the ICU did that made them feel cared for. A brief description of the CARE-Q instrument was given, and the patients were assured that the instrument did not evaluate the individual nurses or the ICU. The patients were told that their participation was voluntary, and that they could withdraw from the study at any time without negative consequence. Confidentiality was assured. Also, it was emphasized that their medical and nursing care had precedence over the study, and that if they experienced fatigue while doing the study, they should stop and rest. Finally, patients were advised that no benefits were offered for participating in this study.

Patients who agreed to participate were asked to sign a consent form (see Appendix D) and fill out a demographic data sheet (see Appendix E). A number was assigned at this time for data use. Detailed verbal and written instructions were given for completing the CARE-Q instrument. First, the deck of CARE-Q cards was given to the patients and they were instructed to sort the cards

according to how important the behavior stated on each card was in making them feel cared for (see Appendix B). Second, the CARE-Q folder with the seven pockets was given to them, and they were told that the most important item should be placed in the first pocket, the least important in the last pocket, and that the items that inspired no particular feelings of being important or unimportant must be placed in the middle pocket. Finally, the necessity of sorting the correct number of cards into each pocket was emphasized. The number printed on each pocket was pointed out as the number of cards that should be placed in each pocket (see Appendix C).

The participants were visited by the investigator after 18 to 24 hours to check on progress or answer questions. If the CARE-Q was completed at this time, it was picked up. Otherwise, it was picked up after 48 hours, whether the instrument was completed or not. This time limit was necessary in order to minimize confusion of the nursing care on the cardiac unit with that perceived in the ICU.

ICU nurse sample. Meetings were scheduled at change-of-shift on several days over a four-week period in order to request nurse participation in the study. The nurses were told that the purpose of the study was to discover what nurses perceived that they did for patients that made patients feel cared for. Those who agreed to participate were asked to sign consent forms (see Appendix

F) and fill out a demographic sheet (see Appendix G); numbers were assigned for data use. The participants were given the CARE-Q cards and folder with seven pockets, and instructed in their use. They were told to sort the cards from most important to least important, with the middle pocket containing those items perceived as neither important nor unimportant in making a patient feel cared for.

All participants were advised that the data would be kept confidential, and that their participation was voluntary. They were told that no benefits were offered for completing the study.

Most participants completed the CARE-Q at the times of the meetings, taking 45 to 60 minutes. Several asked to keep the CARE-Q to do during breaks and after their shifts. These were retrieved by the investigator at the end of the shifts.

Protection of Human Rights

The study proposal was submitted to and approved by the Human Rights Committees of Montana State University College of Nursing and St. Patrick Hospital, Missoula, Montana (see Appendices H & I).

The only risk to patient participants was fatigue caused by concentrating too long on sorting the CARE-Q cards. Ample time was allowed for completion; participants were instructed to rest if they became tired. Larson

(1981) reported no negative consequences for oncology patients completing the CARE-Q.

There were no risks for nurse participants.

Instrument

The instrument used in this study was the Care Assessment Evaluation Q-sort (CARE-Q) developed by Larson (1981). The following paragraphs discuss the characteristics of the instrument.

Larson (1981) employed several steps in the development of her instrument. Initially, a Delphi survey was conducted with eight consenting nurses who had demonstrated exceptional caring in their nurse-patient relationships. Four mailed rounds of questions were sent to these nurses requesting detailed information pertaining to the components of caring. Additionally, Larson (1981) interviewed 15 patients to elicit information in response to the question, "What is it that nurses do to make you feel cared for?" (1981, p. 48) The patient informants were selected for their extensive experience as patients interacting with nurses. From the responses of the patient group, Larson derived six qualitative scales of caring under which 58 caring behaviors were defined.

The next step involved a panel of 13 faculty members and doctoral students, chosen for their expertise in clinical nursing and research. They addressed issues such

as the accuracy of the defined caring, and under which of the six scales each behavior belonged. Most of the defined behaviors were determined to be consonant with the caring concept, but there was unresolved disagreement over the scales in which certain items belonged. A psychometric expert was then consulted to clear up ambiguities and eliminate irrelevant items. Finally, a questionnaire was presented to three patients and four nurses asking whether each item described a caring behavior and whether each item was clearly stated. At the end of this scrutiny of caring behaviors, 50 items remained.

The final scales and 50 caring behaviors represented basic components of the concept of caring. The first scale, titled Accessible, included six caring behaviors; an example of this scale was, "Checks on the patient frequently." The second scale, Explains and Facilitates, contained six items; an example was, "Suggests questions for the patient to ask his/her doctor." Comforts, the third scale, included nine items such as "Listens to the patient." The fourth scale, Anticipates, contained five caring behaviors, one of which was "Knows when the patient has 'had enough' and acts accordingly, e.g., rearranges an examination, screens visitors, insures privacy." Trusting Relationship, the fifth scale, included 16 items. "Puts the patient first, no matter what else happens" was one example of items in the scale. The final scale, Monitors

and Follows Through, contained eight caring behaviors; an example was, "Gives good physical care to the patient."

The 50 caring behaviors were constructed as descriptive statements having no subject. For example, instead of saying, "the nurse talks to the patient," the item read, "talks to the patient." Gender bias was eliminated by including pronouns for both sexes where applicable, i.e., he/she (see Appendix J).

The Q-sort instrument included seven pockets for sorting the 50 nurse caring behaviors in a quasi-normal distribution. The first pocket was labeled "most important," and the one card with the caring behavior most important to the study participant was to be placed there. The second pocket was labeled "fairly important" and four cards were to be placed there. Ten cards were to be placed in the third pocket, titled "somewhat important." The fourth pocket was considered neutral and had no heading. It was to contain the 20 cards that the participant had the least positive or negative perceptions about. The fifth, sixth, and seventh pockets were labeled "Somewhat unimportant," "unimportant," and "not important," and were to hold ten cards, four cards, and one card, respectively. These pockets represented the nurse caring behaviors that had the least importance in making patients feel cared for. The number of cards belonging in each pocket was printed on each pocket. Complete written instructions for sorting the

cards were included (see Appendices B & C).

Testing of the validity and reliability of the CARE-Q developed by Larson (1981) consisted of two major steps. The validity was investigated in the final survey of three patients and four nurses; the survey participants were asked whether the items were caring behaviors and whether the items were clearly stated. Two items were eliminated as a result of this test. Test-retest reliability was conducted on the final CARE-Q instrument, utilizing undergraduate nursing students ($N = 9$). The tests, given one week apart, revealed exact correlation pertaining to the single items placed in the most important and least important pockets. However, there was no significant correlation demonstrated between any of the other sorted items. Larson indicated that ordinary tests of internal consistency could not be performed because the scales of the CARE-Q were derived from a qualitative source, the patient interviews (Personal communication, 1986).

Statistical Method

Descriptive statistics were used to summarize and explain the data obtained in this study. The demographic data within each group were examined for relevance and homogeneity. Each item of the CARE-Q was coded 1 through 50 (see Appendix J). The seven pockets for sorting the items were coded in descending order, seven representing

"most important" and one representing "not important."

Mean scores and standard deviations for each of the CARE-Q items were calculated. This consisted of multiplying the frequency of responses in a given pocket by the pocket code number, adding the products together, then dividing by the sample size of 25. Following the calculation of the mean scores, the nurse-caring behaviors for both groups were rank ordered from the highest mean scores to the lowest in order to answer the research questions.

CHAPTER IV

DATA ANALYSIS

Introduction

The intent of this study was to describe similarities and differences in perceptions of caring between angioplasty/ICU patients and ICU nurses. The CARE-Q instrument was administered to 25 patients and 25 nurses. The completed Q-sort instruments provided data for examining the group responses in this study, and comparing the group responses in this study with the responses of the groups in Larson's study (1981).

Demographic Information

Patient Sample

Approximately 60 patients were approached over a period of 6 months in order to obtain a sample of 25 participants. Twenty-nine persons agreed to participate. Of those who agreed, 4 Q-sort instruments were disqualified. One participant did not complete the CARE-Q due to fatigue. The other 3 did not follow directions and sorted the CARE-Q items at random. Most of the patients who declined to participate gave no specific reason, only that they were not interested. Four candidates declined to participate

because of very negative ICU experiences.

The patient sample consisted of 21 males and 4 females. Their ages ranged from 36 to 80, with a mean of 59 years of age. Thirteen of the 25 participants had never been in an ICU before. Nine were from towns with population of 10,000 or less, while 16 were from towns or cities of greater than 10,000.

Nurse Sample

Thirty ICU nurses were asked to participate in the study over a 4-week period of time. Four nurses declined to participate because of lack of time or other commitments. Of those who agreed to participate, 1 instrument was disqualified because the CARE-Q cards were sorted in a random fashion rather than as the directions had specified.

The ICU nurse sample consisted of 22 females and 3 males. Their ages ranged from 24 to 41, with a mean of 31 years of age. Educational preparation of the nurse sample included 8 with diplomas, 5 with associate degrees, and 12 with baccalaureate degrees. Experience as registered nurses ranges from 2 to 24 years, with a mean of 9. Nurse participants had worked in ICU from 1 to 18 years; the average time was 6 years. Nineteen nurses held staff positions, while 5 were charge nurses, and 1 was a head nurse. Of the 25 participants, 20 indicated that 50% or more of their time was spent in direct patient care.

CARE-Q DataResearch Question 1

The first research question asked, "What nurse caring behaviors are perceived as most important by the angioplasty/ICU patients and ICU nurses?" The top nurse caring behaviors selected by the patients can be found in Table 1; those selected by the nurses are illustrated in Table 2.

The highest mean score ($\bar{M}$ = 5.440) in the patient sample was for the item, "Knows how to give shots, I.V.s, etc...." This caring behavior was from the Monitors and Follows Through scale. The 10 top mean score items within the patients sample represented only 4 of the 6 scales. The Assessable (items 4, 5, & 6) and Monitors and Follows Through scales (items 46, 48, & 50) accounted for 3 times each, while the Trusting Relationship (items 36 & 42) and Comforts (items 16 & 19) scales each had 2 items. No items from the Anticipates or Explains and Facilitates scales were included in the top 10 CARE-Q items (Table 1).

The highest mean score item for the nurse group was "Is calm" ($\bar{M}$ = 5.240) from the Monitors and Follows Through scale. Items from all 6 scales were included in the top 10 CARE-Q items. Because the tenth highest mean score was the same for 3 nurse caring behaviors ($\bar{M}$ = 4.560), 12 items comprise the table. Five items were from the Monitors and Follows through scale (items 45, 46, 47, 48, & 50), and 2

Table 1. Top Ten Mean Score CARE-Q Items for Patients
(N = 25).

No.	Scale	Item No.	Item	M	Agreement with Nurses
1	M & F	46	Knows how to give shots, I.V.s, etc. and how to manage the equipment like I.V.s, suction machines, etc.	5.440	A
2	Acc.	5	Gives a quick response to the patient's call.	5.320	A
3	M & F	50	Knows when to call the doctor.	5.120	A
4	TR.	36	Puts the patient first, no matter what else happens.	4.720	A
5	C	16	Is cheerful.	4.720	
6	Acc.	4	Checks on the patient frequently.	4.720	
7	Acc.	6	Encourages the patient to call if he/she has problems.	4.680	A
8	M & F	48	Gives good physical care to the patient.	4.640	A
9	TR.	42	Introduces himself/herself and tells the patient what she/he does.	4.520	
10	C	19	Listens to the patient.	4.480	A

A - Nurses agree on highest ten mean score item.

Legend: M & F = Monitors and Follows Through
 Acc. = Accessible
 TR. = Trusting Relationship
 C = Comforts
 E & F = Explains and Facilitates
 Antic. = Anticipates

Table 2. Top Ten Mean Score CARE-Q Items for Nurses
(N = 25).

No.	Scale	Item No.	Item	M	Agreement with Patients
1	M & F	47	Is calm.	5.240	
2	C	19	Listens to the patient.	5.200	A
3	TR.	36	Puts the patient first, no matter what else happens.	4.880	A
4	M & F	50	Knows when to call the doctor.	4.840	A
5	C	20	Talks to the patient.	4.720	
6	M & F	45	Is well organized.	4.680	
7	E & F	12	Is honest with the patient about his medical condition.	4.680	
8	M & F	46	Knows how to give shots, I.V.s, etc. and how to manage the equipment...	4.640	A
9	Acc.	6	Encourages the patient to call if he/she has problems.	4.600	A
10*	Acc.	5	Gives a quick response to the patient's call.	4.560	A
	M & F	48	Gives good physical care to the patient.	4.560	A
	Antic.	25	Is perceptive of the patient's needs and plans and acts accordingly...	4.560	

* Because the 10th place included three items with the same mean score, all are included.

A - Patients agree on highest ten mean score item.

each from the Comforts (items 19 & 20) and Accessible (items 5 & 6) scales. One item from each of the remaining 3 scales appeared in the table (Table 2).

Seven of the items in the 10 highest mean scores were the same for the patient (pt.) and nurse (R.N.) groups. They were item 19) "Listens to the patient" (pt. $\underline{M}$ = 4.480, R.N. $\underline{M}$ = 5.200); item 36) "Puts the patient first, no matter what else happens" (pt. $\underline{M}$ = 4.720, R.N. $\underline{M}$ = 4.880); item 50) "Knows when to call the doctor" (pt. $\underline{M}$ = 5.120, R.N. $\underline{M}$ = 4.840); item 46) "Knows how to give shots, I.V.s, etc..." (pt. $\underline{M}$ = 5.440, R.N. $\underline{M}$ = 4.640); item 6) "Encourages the patient to call if he/she has problems" (pt. $\underline{M}$ = 4.680, R.N. $\underline{M}$ = 4.600); item 5) "Gives a quick response to the patient's call" (pt. $\underline{M}$ = 5.320, R.N. $\underline{M}$ = 4.560); and item 48) "Gives good physical care to the patient" (pt. $\underline{M}$ = 4.640, R.N. $\underline{M}$ = 4.560). Three of the items were from the Monitors and Follows Through scale (items 46, 48, & 50), 2 from the Accessible scale (items 5 & 6), and 1 each from the Trusting Relationship (item 36) and Comforts (item 19) scales.

Research Question 2

The second research question was, "What nurse caring behaviors are perceived as least important by the angioplasty/ICU patients and ICU nurses?" The resulting 10 lowest mean score items for patients and nurses can be found in Tables 3 and 4 respectively.

Table 3. Ten Lowest Mean Score CARE-Q Items for Patients
(N = 25).

No.	Scale	Item No.	Item	M	Agreement with Nurses
1	TR.	30	Helps the patient establish realistic goals.	2.960	
2	E & F	8	Helps the patient not feel dumb by giving him/her adequate information.	3.120	
3	M & F	43	Is professional in appearance.	3.200	A
4	TR.	41	Gets to know the patient as an individual person.	3.200	
5	TR.	32	Checks her/his perceptions of the patient with the patient before initiating any action...	3.240	
6	C	17	Sits down with the patient.	3.240	A
7	TR.	29	Offers reasonable alternatives to the patient...	3.360	A
8	C	21	Involves the patient's family or significant others in their care.	3.400	
9	Antic.	24	Knows when the patient has 'had enough' and acts accordingly...	3.400	
10	E & F	11	Suggests questions for the patient to ask her/his doctor.	3.520	A

A - Patients agree on lowest ten mean score item.

Table 4. Ten Lowest Mean Score CARE-Q Items for Nurses
(N = 25).

No.	Scale	Item No.	Item	M	Agreement with Patients
1	M & F	43	Is professional in appearance.	2.640	A
2	C	17	Sits down with the patient.	3.000	A
3	TR.	31	Checks out with the patient the best time to talk with the patient about changes in his/her condition.	3.040	
4	Acc.	2	Volunteers to do "little" things for the patient.	3.080	
5	E & F	11	Suggests questions for the patient to ask her/his doctor.	3.120	A
6	E & F	7	Tells the patient of support systems available.	3.280	
7	TR.	28	Continues to be interested in the patient.	3.480	
8	M & F	44	Makes sure that professional appointment scheduling are realistic.	3.480	
9	TR.	29	Offers reasonable alternatives to the patient.	3.520	A
10	Antic.	26	Anticipates that the 'first times' are the hardest.	3.560	

A - Patients agree on lowest ten mean score item.

The lowest mean score item for the patient sample was CARE-Q item 30, "Helps the patient establish realistic goals" ($\underline{M}$ = 2.960). All the scales except the Accessible scale contained items found in the lowest 10. The Trusting Relationship scale accounted for 4 items (items 29, 30, 32, & 41), while the Explains and Facilitates (items 8 & 11) and Comforts (items 17 & 21) scale each had 2 items (Table 3).

The lowest mean score item for the nurse sample was CARE-Q item 43, "Is professional in appearance - wears appropriate identifiable clothing and identification" ($\underline{M}$ = 2.640). The 10 lowest scores included items from all 6 scales. Three were from the Trusting Relationship scale (items 28, 29, & 31), while the Explains and Facilitates (items 7 & 11) and Monitors and Follows Through (items 43 & 44) scales each had 2 (Table 4).

Four of the 10 lowest mean scores items appeared on both the patient and nurse tables. They were item 11) "Suggests questions for the patient to ask her/his doctor" (pt. $\underline{M}$ = 3.520, R.N. $\underline{M}$ = 3.120); item 29) "Offers reasonable alternatives to the patient..." (pt. $\underline{M}$ = 3.360, R.N. $\underline{M}$ = 3.520); item 17) "Sits down with the patient" (pt. $\underline{M}$ = 3.240, R.N. $\underline{M}$ = 3.000); and item 43) "Is professional in appearance..." (pt. $\underline{M}$ = 3.200, R.N. $\underline{M}$ = 2.640). The 4 items were all in different scales--Explains and Facilitates, Trusting Relationship, Comforts, and Monitors

and Follows Through scales, respectively.

Comparison to Larson's Data

The data from this study were compared to the data from Larson's (1981) study to answer research questions 3 and 4. Larson's samples consisted of 57 oncology patients and 57 nurses who cared for oncology patients. Nurses were drawn from various departments within three hospitals, such as general medical units, out-patient clinics, and oncology units. The patient participants had a variety of oncologic diagnoses, and were experiencing different forms of cancer therapy.

Research Question 3

The 10 highest and lowest mean score items for patients and nurses from this study were compared with those from Larson's study to answer research question 3: "Do similarities exist between the results of this study and Larson's study?"

Highest 10 mean score items. Six of the nurse caring behaviors in the highest 10 were the same in the patient sample from Larson's study and the present study. They were item 46) "Knows how to give shots, I.V., etc...", item 5) "Gives a quick response to the patient's call," item 50) "Knows when to call the doctor," item 4) "Checks on the patient frequently," item 48) "Gives good physical care to the patient," and item 19) "Listens to the patient." Three

of these items were from the Monitors and Follows Through scale (items 46, 48, & 50), 2 were from the Accessible scale (items 5 & 6), and 1 from the Comforts scale (item 19). The highest mean score item was the same for the patient samples of both studies, "Knows how to give shots, I.V.s, etc..." (Vanek pt. $\bar{M}$ = 5.440, Larson pt. $\bar{M}$ = 5.035). (See Appendix K for comparison table).

There was agreement on 6 of the highest mean score items among the nurse groups from both studies. They were item 19) "Listens to the patient," item 36) "Puts the patient first, no matter what else happens," item 20) "Talks to the patient," item 5) "Gives a quick response to the patient's call," item 48) "Gives good physical care to the patient," and item 15) "Is perceptive of the patient's needs and plans and acts accordingly...." Two of the items were from the Comforts scale (items 19 & 20), and 1 each from the Trusting Relationship (item 36), Accessible (item 5), Anticipates (item 25), and Monitors and Follows Through (item 48) scales.

Lowest 10 mean score items. Four of the 10 lowest mean score items from the patient sample of this study appeared in the 10 lowest for the patient group in Larson's (1981) study. They were item 10) "Helps the patient establish realistic goals," item 43) "Is professional in appearance....," item 17) "Sits down with the patient," and item 29) "Offers reasonable alternatives to the patient...."

Two of the items were from the Trusting Relationship scale (items 29 & 30), while the other 2 were from the Comforts (item 17) and Monitors and Follows Through (item 43) scales.

Seven of the 10 lowest mean score items were the same for the nurse groups in both studies. They were item 43) "Is professional in appearance....," item 31) "Checks out with the patient the best time to talk about changes in his/her condition," item 2) "Volunteers to do 'little things' for the patient....," item 11) "Suggests questions for the patient to ask his/her doctor," item 7) "Tells the patient of support systems available....," item 44) "Makes sure that professional appointment scheduling...are realistic to the patient's situation and condition," and item 29) "Offers reasonable alternatives to the patient...." The item with the lowest mean score was the same for both nurse samples. It was "Is professional in appearance - wears appropriate identifiable clothing and identification" (Vanek $\bar{M}$ = 2.640, Larson $\bar{M}$ = 2.4912). Two items were from the Trusting Relationship scale (items 29 & 31), 2 from the Monitors and Follows Through scale (items 43 & 44), and 2 more from the Explains and Facilitates scale (items 7 & 11). The Accessible scale had 1 item (item 2).

Comparison of Highest to Lowest Mean Score Items

In this study none of the items in the 10 highest mean score items of one group were found among the lowest 10

mean score items of the other group. However, in Larson's (1981) study "Is well organized" was included in the 10 highest mean score items for the patient sample ($\bar{M} = 4.3508$) and in the 10 lowest mean score items of the nurse sample ($\bar{M} = 3.5789$). "Is well organized" ($\bar{M} = 4.680$) was also found among the 10 highest mean score items for the ICU nurse group of this study. The nurse sample in Larson's study included "Is cheerful" in the 10 lowest mean score items ($\bar{M} = 3.3157$); the item was among the 10 highest for the ICU/angioplasty patients of this study ($\bar{M} = 4.720$).

Research Questions 4

Research question 4 asked, "Do the angioplasty/ICU patients and ICU nurses in this study agree more closely on the ranking of the nurse caring behaviors than the patients and nurses in Larson's study?" Data relevant to this determination are illustrated in Appendix K.

The patient and nurse groups in Larson's (1981) study were in agreement on 5 of the 10 highest mean score items while the groups in this study agreed on 7 out of 10. All the groups showed 4 of the same items in the highest 10. They were item 5) "Gives a quick response to the patient's call, item 48) "Gives good physical care to the patient," item 36) "Puts the patient first, no matter what else happens," and item 19) "Listens to the patient." All the items were in different scales--Accessible (item 5),

Monitors and Follows Through (item 48), Comforts (items 19), and Trusting Relationship (item 36) scales.

The patient and nurse samples in Larson's study were in agreement on 6 of the 10 lowest mean score items. The two groups in the present study were in accord on 4 items. All four groups agreed on 2 of the 10 lowest mean score items. They were item 43) "Is professional in appearance..." and item 29) "Offers reasonable alternatives to the patient....," from the Monitors and Follows Through and Trusting Relationship scales, respectively.

Summary

Following the description of the study participants based on the demographic information sheets, mean scores for the CARE-Q items were calculated and rank ordered. The ensuing data were generated to answer the four research questions. The 10 highest and lowest mean CARE-Q items for the angioplasty/ICU patients and ICU nurses were examined within and between groups for similarities and differences. A comparison was then made of the 10 highest and lowest mean score items from the patient and nurse groups in Larson's (1981) study to determine similarities. Finally, the same data were examined to evaluate which patient and nurse groups agreed more closely on important nurse caring behaviors.

CHAPTER V

DISCUSSION, SUMMARY, LIMITATIONS, AND RECOMMENDATIONS

Discussion

The data generated from the completed CARE-Q instruments of 25 angioplasty/ICU patients and 25 ICU nurses allowed comparisons of the 10 highest and lowest mean score items between the groups, as well as between the patient and nurse groups and Larson's (1981) study. Dominant themes emerged demonstrating the degree of concurrence between groups. In addition, certain individual items appeared which merit discussion.

Themes of Caring

Highest mean score items. The scales most frequently represented by the highest mean score items for both the patient and nurse groups were the Monitors and Follows Through and Accessible scales. Larson (1981) described the caring activities of the former scale as physical skills, continuity of care, and professional attributes. The latter scale represented behaviors in which the nurse was viewed as easily available to the patient and/or initiating interventions without the patient having to request them.

Patient participants. Six of the 10 highest mean score items for the angioplasty/ICU patients were from the

above two scales. This preference for activities related to themes of skill competence and "being there" was not surprising. Many of the participants praised the ICU nurses who had cared for them by saying, "They sure knew what they were doing" and "They stayed on top of the situation." The comparison of this study's patient group with the oncology patient group of Larson's study (N = 57) substantiated the importance of these themes; 7 of the 10 highest mean score items for Larson's sample were from the Monitors and Follows Through and Accessible scales. The highest mean score item, "Knows how to give shots, IVs, and etc...", was identical for both patient groups. Based in the findings of these two studies caring activities related to skill competence and "being there" were most important to patients in life-threatening situations, whether acute or chronic. Patients perceived that their survival depended on the physical activities of caring; therefore, other expressions of caring were considered less important. Based on Brown's (1981) statement that caring was "a way of being coupled with a way of doing," it is plausible that skill competence and availability must be perceived for other caring themes to be enacted. Nurses who are not accessible may not be able to provide comfort; and patients may not feel trust if the nurses do not express skill competence.

Nurse participants. The ICU nurse participants also perceived caring behaviors in the Monitors and Follows

Through and Accessible scales as most important, with 7 items from these scales placed in the highest 10 mean scores. The experience of working in the ICU may have influenced the top ranking of the item, "Is calm" from the Monitors and Follows Through scale. It is logical that those experiencing the constraints of time and complex interventions would focus on this attribute. The performance of tasks is more efficient, and the psychological impact of a crises is blunted when the nurses appear calm.

The oncology nurses (N = 57) in Larson's study worked outside the ICU; the different care environment may account for the difference in caring themes which they considered most important. Only 2 of the 10 highest mean score items were from the Monitors and Follows Through and Accessible scales, while 7 items represented the Trusting Relationship and Comforts scales. Nurses outside the ICU have less exposure to each patient because they care for more patients. Also, the medical interventions are usually less complex as well as less critical. Therefore, survival of the patient, which would demand physical skills and immediate availability, was not the primary focus of caring as it seemed to be for the ICU nurses.

Lowest Mean Score Items

The themes that emerged from examination of the lowest mean score items for the patient and nurse groups of this

study further substantiate the importance of physical caring and "being there." The Monitors and Follows Through and Accessible scales were represented by only 1 and 3 items in the respective groups. The Trusting Relationship scale had the most items in the lowest 10 mean scores for both groups. Larson (1981) described the Trusting Relationship theme as a reciprocal process involving components of "...individuality; validating; confidentiality; and friendliness" (p. 164).

Patient participants. Four of the 10 lowest mean score items for the ICU patient participants were from the Trusting Relationship scale. "Helps the patient establish realistic goals," from this scale, had the lowest mean score. A rationale for these findings is that patients in the ICU by surrendering their independence were able to adopt trusting relationships without adjunctive behaviors by the nurses. Therefore, caring activities to inspire trust were considered redundant. An examination of the lowest mean score items for the patient group in Larson's study (1981) revealed that half (5) were from the Trusting Relationship scale. These findings indicated that it is possible that patients enter into a nurse-patient relationship with a degree of trust already established.

Nurse participants. The 10 lowest mean scores of the ICU nurses contained more items from the Trusting Relationship scale (3) than from any other. The reason for

the finding was probably the same as for the ICU patients; the nurses accept patients into their care assuming a measure of trust. The time-restricted environment of the ICU limits "niceties" such as "Offers reasonable alternatives to the patient..." that could encourage patient trust. Items from the other scales included in the lowest mean scores substantiate that ICU nurses perceived that time diverted from task-oriented activities was wasted time.

The lowest mean scores for the nurses from Larson's study contained two equally dominant scales: Monitors and Follows Through (3) and Trusting Relationship (3). This finding of the 3 items from Monitors and Follows Through scale further substantiates the differing foci of caring between the two nursing groups.

Concurrence Between Patient and Nurse Groups

The angioplasty/ICU patients and ICU nurses concurred on 7 of the highest mean score items; this finding demonstrated strong agreement between the two groups as to how caring is best expressed. Five of the items were related to skill competence and "being there," while items of comfort and trust provided depth to these themes. Larson's patients and nurses had 5 identical items in the top 10 mean scores. Three items were comfort and trusting behaviors, the dominant themes of the nurse group. Because the oncology nurse group placed a lower value on skill

competence and "being there" than the oncology patient group weaker agreement between the two groups was demonstrated than in this study.

This perception was substantiated by a comparison of the patient group items; 7 identical items appeared among the highest mean scores in both studies. The prevailing themes were physical caring and availability, while the identical highest mean score item described skill competence. Although the patient group participants were very different in terms of diagnosis, treatment environment, and demographic variables between the two studies, the activities determined to be the most important for caring were very similar.

Six of the ten highest mean score items were the same for the ICU and oncology nurse groups. Two were from the Monitors and Follows Through and Accessible scales, while 3 were from the Comforts and Trusting Relationship scales. The identical items reflected fragments of the themes of each nurse group, and agreement was slightly weaker than between the patient groups.

Findings Related to Individual Items

Most important caring behaviors. The patient and nurse groups of this and Larson's study agreed on 4 of the highest mean score nurse caring behaviors. These items appear to be basic to the profession of nursing and as such, provide a foundation for the growth of the concept of

caring in the acute care clinical setting. The items are, a) "Puts the patient first no matter what else happens," b) "Gives a quick response to the patient's call," c) "Gives good physical care to the patient," and d) "Listens to the patient." All are from different scales, indicating the multidimensional nature of caring.

Least important nurse caring behaviors. The four groups all ranked 2 behaviors as least important to caring. The items were a) "Is professional in appearance..." and b) "Offers reasonable alternatives to the patient...." While both items may convey caring, the nurses and patients in a busy acute care clinical environment placed a lower value on these two nurse caring behaviors.

Discrepancies in the Perception of Caring Behaviors

The item, "Is well organized," was perceived quite differently by the patient and nurse groups. The ICU nurses and Larson's oncology patients ranked the item among the highest caring behaviors. The oncology nurses ranked the same item among the 10 lowest caring behaviors. The ability to organize is an important activity for all nurses. Oncology patients may have perceived organization as important because they observed their nurses needing organizational skills in order to care for the large number of patients.

The item "Is cheerful" was ranked among the highest mean scores by the angioplasty/ICU patients, and among the

lowest by the oncology nurses. Possibly the patient group perceived this behavior as important to caring because it meant that the nurses enjoyed the interactions, and were not performing unwelcome tasks for the dependent recipients. On the other hand, the oncology nurses may have felt that being cheerful conveyed insensitivity to the patients with serious diagnoses who were receiving painful and debilitating modes of therapy.

Summary

The themes of physical caring and availability emerged as most important to caring from examination of the highest and lowest mean score items of angioplasty/ICU patients and ICU nurses. Comparison with Larson's study of oncology patients and oncology nurses revealed that the same two themes were important to oncology patients. Additionally, the patients and nurses of this study agreed more closely in the ranking of nurse caring behaviors than those of Larson's study. However, CARE-Q items of agreement included some related to themes other than the Monitors and Follows Through and Accessible scales. This finding validates the multidimensional nature of caring, a balance of behaviors that will provide the most benefit to the patient.

Limitations of the Study

There were limitations to this study about perceptions of important nurse caring behaviors. First, the patient and nurse participants did not constitute random samples. Convenience samples were necessary due to constraints of time and geography. Secondly, the sample size of 25 in each group was small. However, the results of this study can be generalized to other ICU environments with the same populations.

Suggestions for Future Study

The degree of agreement between this and Larson's study shows the potential value of further information concerning the concept of caring. Research in ICUs using larger samples and continued use of the CARE-Q instrument to assess perceptions are necessary to build and refine knowledge about caring behaviors in the ICU.

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REFERENCES CITED

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APPENDICES

APPENDIX A

Permission to Use Instrument

School of Nursing
Department of Physiological
Nursing, N 811Y
San Francisco, CA 94143

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



July 5, 1984

Ms. Gretchen Balthaser
2323 West Crescent Drive
Missoula, MT 59801

Dear Ms. Balthaser:

Thank you for your inquiry about my Caring Assessment Instrument (the CARE-Q). It is rewarding to know that others are interested in exploring the caring construct in clinical nursing practice.

I am enclosing the CARE-Q instrument as well as pertinent information about the development of the instrument you may find helpful in your use of the instrument. Feel free to call me if you have further questions.

You are free to use the CARE-Q as long as you acknowledge my authorship (as noted it is under my copyright). If you decide to use the CARE-Q I would appreciate receiving a brief synopsis of your study results. It is important that an account is kept of the various populations and results associated with the CARE-Q. I will treat this information confidential unless you indicate that it may be shared with others.

If you are interested in pursuing the caring in an on-going basis I encourage you to look for the announcement of the National Caring Conferences held in the spring of each year. The 1985 conference will be held at the University of Colorado. I have found these conferences most beneficial.

Sincerely,


PATRICIA J. LARSON, R.N., D.N.S.
Assistant Clinical Professor

PJL:rjf

Enc

*October -
due to the final
packet of information
CARE-Q
July 9*

APPENDIX B

CARE-Q Item

Helps the patient not to
feel dumb by giving him/her
adequate information.

CARE-Q item

3" x 5" cards

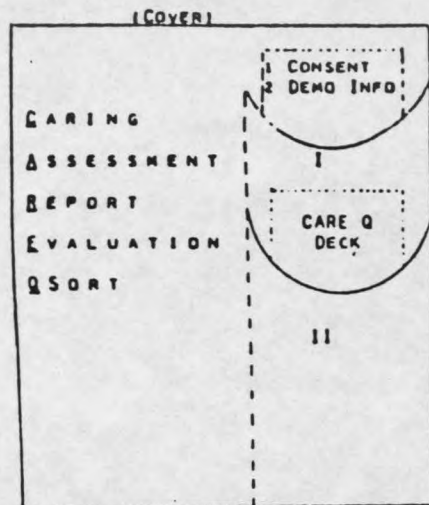
3145

→ for use in computer program CARE-Q
Item Identification
(numbers were derived arbitrarily
to avoid influencing subject
sorting)

Most Important

1

Library card pocket (3½")



DIRECTIONS

- 1) READ AND SIGN CONSENT FORM FOUND IN POCKET.
- 2) PLEASE ANSWER THE QUESTIONS FOUND ON THE DEMOGRAPHIC INFORMATION SHEET.
- 3) TAKE THE PILE OF CARDS FROM PACKET AND SORT THEM INTO POCKETS BELOW IN THE FOLLOWING MANNER:
 - POCKET A** - PLACE ONE (1) CARD WITH STATEMENT ABOUT AN R.N. WHICH YOU BELIEVE IS THE MOST IMPORTANT THING R.N.'S CAN DO TO MAKE PATIENTS FEEL CARED FOR.
 - POCKET B** - PLACE FOUR (4) CARDS WHICH ARE NEXT IN IMPORTANCE IN MAKING PATIENT FEEL CARED FOR.
 - POCKET C** - PLACE TEN (10) CARDS WHICH ARE NEXT IN IMPORTANCE, THOSE THINGS WHICH ARE OF SOMEWHAT IMPORTANCE IN MAKING PATIENT FEEL CARED FOR.
 - POCKET D** - PLACE THE TWENTY (20) CARDS WHICH ARE NICE, BUT NEITHER IMPORTANT OR UNIMPORTANT IN MAKING A PATIENT FEEL CARED FOR.
 - POCKET E** - PLACE THE TEN (10) CARDS WHICH ARE SOMEWHAT UNIMPORTANT IN MAKING A PATIENT FEEL CARED FOR.
 - POCKET F** - PLACE THE FOUR (4) CARDS WHICH ARE RATHER UNIMPORTANT IN MAKING A PATIENT FEEL CARED FOR.
 - POCKET G** - (THE LAST POCKET). PLACE THE ONE (1) CARD WITH THE STATEMENT WHICH IS NOT IMPORTANT IN MAKING PATIENT FEEL CARED FOR.
- 4) PLEASE COUNT THE NUMBER OF CARDS IN EACH POCKET TO MAKE SURE THAT THE RIGHT NUMBER OF CARDS ARE IN EACH POCKET.

MOCK-UP OF CARE Q PACKET

(INSIDE OF PACKET)

A	B	C	D	E	F	G
MOST IMPORTANT	FAIRLY IMPORTANT	SOMEWHAT IMPORTANT	NEITHER IMPORTANT OR UNIMPORTANT	SOMEWHAT UNIMPORTANT	RATHER UNIMPORTANT	NOT IMPORTANT
1	4	10	20	10	4	1

NUMBERS PRINTED IN RED. WORDS PRINTED IN BLACK.

CARE-Q Packet

APPENDIX C

APPENDIX D. Patient Consent Form

Montana State University

Patient

Consent to Act as a Participant

in the

Nurse Caring Behavior Study

The purpose of this study, as explained to me by Ms. Gretchen B. Vanek, a student in the Master of Nursing program at Montana State University, is to find out which nurse behaviors are most important in making patients feel cared for. I will not be evaluating any specific nurse, but will be indicating the nurse behaviors I think are the most important in patient-nurse interactions in the intensive care unit (ICU).

To participate in the study I will sort cards containing statements about caring behaviors by nurses, rating them from most important to least important. This will require about 45 to 60 minutes of my time. I can stop and rest and continue on when I choose. I will participate in the study at my convenience, up to 48 hours after my transfer from the ICU. I understand that my medical and nursing care take precedence over the study.

There will be no benefits to me personally from participating in the study, however, the information gained from the study may help nurses give better care to patients.

Ms. Vanek has assured me that my responses will be kept confidential. She also has assured me that my care will not be affected by my decision to either participate or not participate in the study. Also, I can withdraw from the study at any time, for any reason.

I agree to participate in the "Important Nurse Caring Behaviors" study as described to me by Gretchen Vanek.

If I have any questions regarding this study, I may contact Ms. Vanek by calling _____.

Date: _____

Signature: _____

Copy for investigator and subject.

APPENDIX E. Patient Demographic Information

Patient Demographic Information

Note: All information on this sheet is confidential.

Patient sample number _____

1. Age: _____ 2. Sex: _____

3. Primary occupation: _____

4. How many times have you been a patient in the hospital before?
(circle one)

0 1 2 3 4 5 or more

5. Have you ever been a patient in any kind of critical care unit
before? (i.e., ICU, CCU, surgical ICU) (check one)

Yes _____ No _____ Don't Know _____

6. Comments: _____

7. Size of city of residence:

_____ 0 to 5,000

_____ 5,001 to 10,000

_____ 10,001 to 20,000

_____ over 20,000

Appendix F. Nurse Consent Form

Montana State University

Nurse

Consent to Act as a Participant

in the

Nurse Caring Behavior Study

The purpose of this study, as explained to me by Ms. Gretchen B. Vanek, a student in the Master of Nursing program at Montana State University, is to find out which caring behaviors nurses believe are most important in making patients feel cared for.

To participate in the study, I will sort cards containing statements about nurse caring behaviors, rating them from most important to least important. This will require about 45 to 60 minutes of my time.

There will be no benefits to me personally from participating in the study, however, the information gained from the study may help ICU nurses to give better care to patients.

Ms. Vanek has assured me that my responses will be kept confidential, and my right to privacy will be protected.

I agree to participate in the "Nurse Caring Behavior Study" as described to me by Ms. Gretchen Vanek.

If I have any questions regarding this study, I may contact Ms. Vanek by calling _____.

Date: _____

Signature: _____

Copy for investigator and subject.

APPENDIX G

Nurse Demographic Information

note: All information on this sheet is confidential.

- 1) Age _____
- 2) Female _____ Male _____
- 3) Employment status:
_____ Full-time (33 hours or more a week)
_____ Part-time (32 hours or less a week)
- 4) Present position:
_____ Staff nurse _____ Nurse clinician
_____ Charge nurse _____ Other (please
_____ Head nurse indicate) _____
- 5) Total number of years as a registered nurse (R.N.):

- 6) Total number of years worked in intensive care:

- 7) Level of education in nursing:
_____ Diploma
_____ Associate degree (A.D.N.)
_____ Baccalaureate degree (B.S.N.)
_____ Master's degree (M.S.M., M.N.)
_____ Other (please explain) _____

8) Please indicate by percentage the amount of time usually spent on each activity in a work day. Consider the total amount of time in a work day to be equal to 100%.

Nursing activities:

_____ Giving direct care to patients (e.g. bath, backrubs, turning, assisting with ambulation).

_____ Carrying out medical orders.

_____ Managing patient symptoms of disease and treatment (e.g. giving pain meds, hemodynamic monitoring)

_____ Coordinating patient activities with other health team members and/or departments.

APPENDIX H

MSU Human Rights Review

RESEARCH PROPOSAL FOR HUMAN SUBJECTS REVIEW

Title of Project: ICU Patients' and ICU Nurses' Perceptions of Important Nurse Caring Behaviors

Investigator: Gretchen T. Balthaser Date 11/3/84

Thesis Committee:

<u>S/ Barbara Buckelew</u>	Chairperson (signed)
<u>S/ Meredith C. Rowe</u>	Committee member (signed)
<u>S/ Eleanor Yurkovich</u>	Committee member (signed)

Please answer the following questions:

1. ☒ Yes ☐ No Does the project involve the administration of personality tests, inventories or questionnaires? If YES, provide the name of the tests, if standard, or a complete copy if not standard.
2. ☐ Yes ☒ No For studies to be conducted at hospitals and clinics do the proposed studies involve the use, methods, techniques or apparatus other than those used routinely at these facilities.
3. Human subjects would be involved in the proposed activity as either:
☒ none of the following, or including: ☐ minors, ☐ fetuses, ☐ abortuses, ☐ pregnant women, ☐ prisoners, ☐ mentally retarded, ☐ mentally disabled.

S/ Gretchen T. Balthaser Date 10/23/84
 Signature of Principal Investigator

APPROVAL (If disapproval, do not sign and append comments).

<u>S/ Cheryl Olson</u>	Date <u>11/19/84</u>
Signature of Education Director	
Committee Member	Date _____
Committee Member	Date _____

APPENDIX I. St. Patrick Hospital Human Rights Review

St. Patrick Hospital
Nursing Research Committee
Screen for Proposed Research

Investigator: Gretchen Vanek Reviewer: Sandy Greene Date Reviewed: 2/13/85

Title of proposed research: ICU Patients' and ICU Nurses' Perceptions of
Important Nurse Caring Behaviors.

Has the study been previously reviewed and accepted for appropriate research methodologies by MSU School of Nursing faculty? Yes

Is the purpose of the proposed study stated clearly? Yes

Can St. Patrick Hospital provide the data being sought? Yes, given sufficient time.

Are the potential risks to the subject stated clearly? Yes (None)

Is the procedure for obtaining informed consent adequate and ethical? Yes

Is any aspect of the study likely to conflict with institutional or departmental philosophy, objectives, or policy? No

Is carrying out the proposal administratively feasible? Yes

Are any other studies being conducted on the same population? No

Is any aspect of the research likely to interfere with current or projected research at St. Patrick Hospital? No

Will patient care management and unit routines be interrupted if the study is conducted?

It shouldn't - will take some staff time.

Are the projected dates or deadlines for data collection reasonable?

Don't know - would there be 25 suitable angioplasties by May '85?

How much staff time is anticipated to be needed?

Recommendations:

Sounds like a good and useful study.

S/ Sandra J. Greene

S/ Sr. Rogene Fox
Assist. Admin. Nursing

APPENDIX J

Means and Standard Deviations of ICU Patients' and ICU Nurses'
Perceptions of Caring Behaviors

<u>The CARE-Q Items and Scales</u>	<u>Patient Group</u>		<u>Nurse Group</u>	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Accessible				
1. Frequently approaches the patient first, e.g., offering such things as pain medication, back rub, etc.	3.9200	0.702	3.8000	0.707
2. Volunteers to do "little things" for the patient, e.g., brings a cup of coffee, paper, etc.	4.1200	0.971	3.0800	1.605
3. Gives the patient's treatments and medications on time.	4.4400	1.121	4.0000	1.291
4. Checks on the patient frequently.	4.7200	1.137	4.4800	1.085
5. Gives a quick response to the patient's call.	5.3200	0.945	4.5600	1.003
6. Encourages the patient to call if he/she has problems.	4.6800	1.030	4.6000	0.866
Explains and Facilitates				
7. Tells the patient of support systems available, such as self-help groups or patients with similar disease.	3.7200	0.936	3.2800	1.061
8. Help the patient not feel dumb by giving him/her adequate information.	3.1200	1.130	3.9200	0.812
9. Tells the patient, in understandable language, what is important to know about his/her disease and treatment.	4.3200	1.030	4.4000	1.000
10. Teaches the patient how to care for himself/herself whenever possible.	3.7600	0.723	3.6000	0.645

<u>The CARE-Q Items and Scales</u>	<u>Patient Group</u>		<u>Nurse Group</u>	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
11. Suggests questions for the patient to ask his/her doctor.	3.5200	0.823	3.1200	1.054
12. Is honest with the patient about his medical condition.	3.9600	1.172	4.6800	1.030

Comforts

13. Provides basic comfort measures, such as appropriate lighting, control of noise, adequate blankets, etc.	4.1200	0.927	3.9200	0.812
14. Provides the patient encouragement by identifying positive elements related to the patient's condition and treatment.	3.5200	1.046	3.7200	0.936
15. Is patient even with "difficult" patients.	4.0400	0.735	4.0400	0.935
16. Is cheerful.	4.7200	0.980	3.6800	0.852
17. Sits down with the patient.	3.2400	1.128	3.0000	1.190
18. Touches the patient when he/she needs comforting.	3.8000	1.658	4.5200	0.963
19. Listens to the patient.	4.4800	1.046	5.2000	0.913
20. Talks to patient.	4.3600	1.150	4.7200	0.737
21. Involves the patient's family or significant others in their care.	3.4000	0.764	4.0000	0.816

Anticipates

22. Realizes that the nights are frequently the most difficult time for the patient.	4.0400	0.889	3.6000	0.816
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<u>The CARE-Q Items and Scales</u>	<u>Patient Group</u>		<u>Nurse Group</u>	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
23. Anticipates the patient's and her/his family's shock over her/his diagnosis and plans opportunities for them, individually or as a group, to talk about it.	3.5600	0.870	3.8400	0.746
24. Knows when the patient has 'had enough' and acts accordingly, e.g., rearranges an examination screens visitors, insures privacy.	3.4000	0.957	3.9600	0.735
25. Is perceptive of the patient's needs and plans and acts accordingly, e.g., gives anti-nausea medication when patient is receiving medication which will probably induce nausea.	4.2400	0.926	4.5600	0.917
26. Anticipates that the 'first times' are the hardest and pays special attention to the patient during these times.	3.9200	1.187	3.5600	0.961

Trusting Relationship

27. When with a patient, concentrates only on that one patient.	4.3200	1.215	3.7200	1.370
28. Continues to be interested in the patient even though a crisis or critical phase has passed.	3.9600	1.172	3.4800	1.005
29. Offers resonable alternatives to the patient, such as choice of appointment times, bath times, etc.	3.3600	0.907	3.5200	1.122
30. Helps the patient establish realistic goals.	2.9600	1.172	3.7600	1.091
31. Checks out with the patient the best time to talk with the patient about changes in his/her condition.	3.4800	0.872	3.0400	0.935

<u>The CARE-Q Items and Scales</u>	<u>Patient Group</u>		<u>Nurse Group</u>	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
32. Checks her/his perceptions of the patient with the patient before initiating any action, e.g., if she/he (the nurse) has the feeling that the patient is upset with the treatment plan, discusses this with the patient before talking about it to the doctor.	3.2400	0.663	3.7200	0.980
33. Helps the patient clarify his thinking in regard to his/her disease and treatments.	3.8800	0.726	3.7200	0.843
34. Realizes that the patient knows himself the best and whenever possible includes the patient in planning and management of his/her care.	3.6000	0.957	4.4800	1.503
35. Encourages the patient to ask her/him any questions he/she might have.	4.0400	0.978	4.5200	1.005
36. Puts the patient first, no matter what else happens.	4.7200	1.100	4.8800	1.641
37. Is pleasant and friendly to the patients's family and significant others.	4.2400	1.200	4.1600	0.554
38. Allows the patient to express his feelings about his/her disease and treatment fully, and treats the information confidentially.	3.9600	1.098	4.3600	1.036
39. Asks the patient what name he/she prefers to be called.	3.8400	1.405	3.6800	1.249
40. Has a consistent approach with the patient.	3.6400	0.860	3.9600	0.935
41. Gets to know the patient as an individual person.	3.2000	1.472	3.6000	1.323
42. Introduces himself/herself and tells the patient what she/he does.	4.5200	1.358	4.0000	1.118

<u>The CARE-Q Items and Scales</u>	<u>Patient Group</u>		<u>Nurse Group</u>	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Monitors and Follows Through				
43. Is professional in appearance—wears appropriate identifiable clothing and identification.	3.2000	1.155	2.6400	1.186
44. Makes sure that professional appointment scheduling, e.g., x-ray, special procedures, etc., are realistic to the patient's condition and situation.	3.6400	1.287	3.4800	0.770
45. Is well organized.	4.1600	1.313	4.6800	0.945
46. Knows how to give shots, IVs. etc., and how to manage the equipment like IVs, suction machines, etc.	5.4400	0.870	4.6400	1.440
47. Is calm.	4.4400	1.227	5.2400	1.200
48. Gives good physical care to the patient.	4.6400	1.411	4.5600	1.158
49. Makes sure others know how to care for the patient.	3.9600	0.539	3.6400	1.114
50. Knows when to call the doctor.	5.1200	1.092	4.8400	1.313

APPENDIX K

Comparison of Ten Most and Least Important Caring Behaviors
in Vanek's and Larson's Studies

<u>The CARE-Q Items and Scales</u>	<u>Most Important Caring Behaviors</u>		<u>Least Important Caring Behaviors</u>	
	<u>Patients</u>	<u>Nurses</u>	<u>Patients</u>	<u>Nurses</u>
Accessible				
1. Frequently approaches the patient first, e.g., offering such things as pain medication, back rub, etc.				
2. Volunteers to do "little things" for the patient, e.g., brings a cup of coffee, paper, etc.				L(41) V(47) L(43)
3. Gives the patient's treatments and medications on time.		L(5)		
4. Checks on the patient frequently.	V(6)	L(9)		
5. Gives a quick response to the patient's call.	V(2)	L(3)	V(10)	L(8)
6. Encourages the patient to call if he/she has problems.	V(7)	V(9)		
Explains and Facilitates				
7. Tells the patient of support systems available, such as self-help groups or patients with similar disease.				L(44) V(45) L(45)
8. Helps the patient not feel dumb by giving him/her adequate information.			V(49)	
9. Tells the patient, in understandable language, what is important to know about his/her disease and treatment.				
10. Teaches the patient how to care for himself/herself whenever possible.				
Legend: V = Vanek L = Larson (1 to 10) = Rating of most important items (41 to 50) = Rating of least important items				

<u>The CARE-Q Items and Scales</u>	<u>Most Important Caring Behaviors</u>		<u>Least Important Caring Behaviors</u>	
	<u>Patients</u>	<u>Nurses</u>	<u>Patients</u>	<u>Nurses</u>
11. Suggests questions for the patient to ask his/her doctor.			V(41)	V(46) L(49)
12. Is honest with the patient about his medical condition.		V(7)		

Comforts

13. Provides basic comfort measures, such as appropriate lighting, control of noise, adequate blankets, etc.				
14. Provides the patient encouragement by identifying positive elements related to the patient's condition and treatment.				
15. Is patient even with "difficult" patients.			L(45)	
16. Is cheerful.	V(5)			L(47)
17. Sits down with the patient.			V(45) L(48)	V(49)
18. Touches the patient when he/she needs comforting.		L(2)		
19. Listens to the patient.	V(10) L(7)	V(2) L(1)		
20. Talks to the patient.	L(8)	V(5) L(5)		
21. Involves the patient's family or significant others in their care.			V(43)	

Anticipates

22. Realizes that the nights are frequently the most difficult time for the patient.				
23. Anticipates the patient's and her/his family's shock over her/his diagnosis and plans opportunities for them, individually or as a group, to talk about it.				
24. Knows when the patient has 'had enough' and acts accordingly, e.g., rearranges an examination, screens visitors, insures privacy.			V(42)	

<u>The CARE-Q Items and Scales</u>	<u>Most Important Caring Behaviors</u>		<u>Least Important Caring Behaviors</u>	
	<u>Patients</u>	<u>Nurses</u>	<u>Patients</u>	<u>Nurses</u>
25. Is perceptive of the patient's needs and plans and acts accordingly, e.g., gives anti-nausea medication when patient is receiving medication which will probably induce nausea.		V(10) L(7)		
26. Anticipates that the 'first times' are the hardest and pays special attention to the patient during these times.			V(41)	

Trusting Relationship

27. When with a patient, concentrates only on that one patient.		L(42)		
28. Continues to be interested in the patient even though a crisis or critical phase has passed.			V(44)	
29. Offers reasonable alternatives to the patient, such as choice of appointment times, bath times, etc.		V(44) L(46)	V(42) L(46)	
30. Helps the patient establish realistic goals.		V(50) L(43)		
31. Checks out with the patient the best time to talk with the patient about changes in his/her condition.			L(49)	V(48) L(48)
32. Checks her/his perceptions of the patient with the patient before initiating any action, e.g., if she/he (the nurse) has the feeling that the patient is upset with the treatment plan, discusses this with the patient before talking about it to the doctor.				
33. Helps the patient clarify his thinking in regard to his/her disease and treatments.				
34. Realizes that the patient knows himself the best and whenever possible includes the patient in planning and management of his/her care.		L(6)		

The CARE-Q Items and Scales	Most Important Caring Behaviors		Least Important Caring Behaviors	
	Patients	Nurses	Patients	Nurses
35. Encourages the patient to ask her/him any questions he/she might have.				
36. Puts the patient first, no matter what else happens.	V(4)	L(6)	V(3)	L(9)
37. Is pleasant and friendly to the patient's family and significant others.				
38. Allows the patient to express his feelings about his/her disease and treatment fully, and treats the information confidentially.				L(3)
39. Asks the patient what name he/she prefers to be called.			L(50)	L(44)
40. Has a consistent approach with the patient.				
41. Gets to know the patient as an individual person.			L(4)	V(47)
42. Introduces himself/herself and tells the patient what she/he does.		V(9)		
Monitors and Follows Through				
43. Is professional in appearance --wears appropriate identifiable clothing and identification.			V(43)	L(47) V(50) L(50)
44. Makes sure that professional appointment scheduling, e.g., x-ray, special procedures, etc., are realistic to the patient's condition and situation.				V(43) L(42)
45. Is well organized.		L(10) V(6)		L(41)
46. Knows how to give shots, IVs, etc., and how to manage the equipment like IVs, suction machines, etc.	V(1)	L(1)	V(8)	
47. Is calm.			V(1)	
48. Gives good physical care to the patient.	V(8)	L(4)	V(10)	L(10)
49. Makes sure others know how to care for the patient.				
50. Knows when to call the doctor.	V(3)	L(2)	V(4)	

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