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.

ICU PATIENTS' AND ICU NURSES'

PERCEPTIONS OF IMPORTANT

NURSE CARING BEHAVIORS

by

Gretchen Torrence Vanek

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ii

APPROVAL

of a thesis submitted by

Gretchen Torrence Vanek

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.

June 16, 1987
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Date _15 June, 1987_

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TABLE OF CONTENTS

TABLE OF CONTENTS – <u>Continued</u>

TABLE OF CONTENTS - <u>Continued</u>

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

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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." ($\underline{M}$ = 5.0350); the nurse sample had "Listens to the patient" as the highest mean score item ($\underline{M}$ = 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 continous 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

Welfare
of
X

Need
for
care

Knowledge
professed
by S

Action
and
Intention
of S
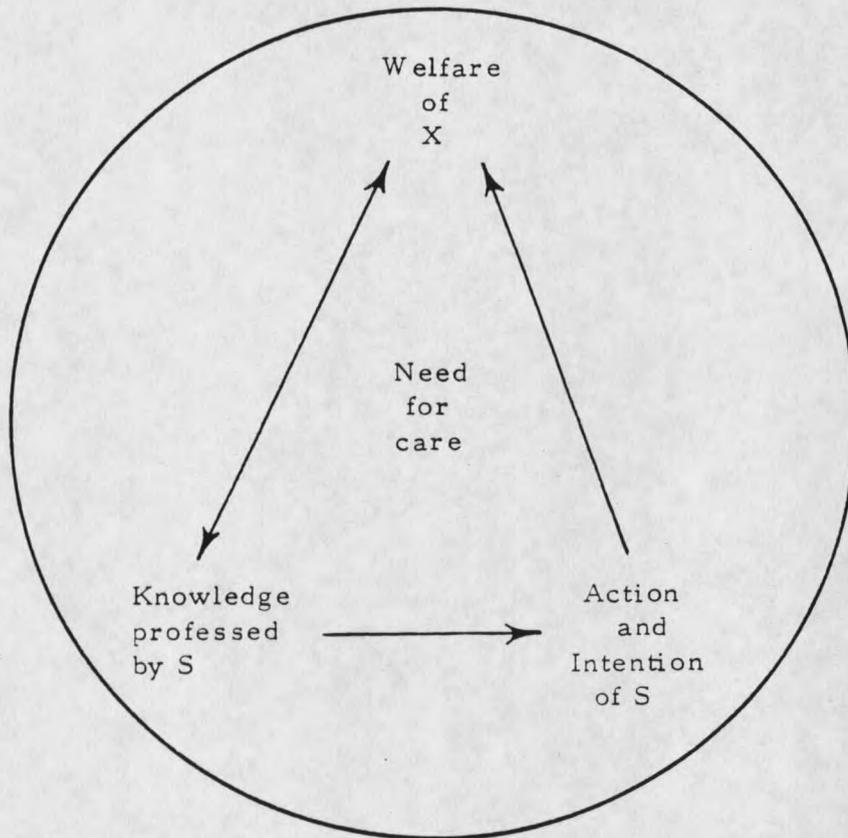
1. S must have knowledge about the need for care (↓) by X. Knowledge is equally as important as the action in achieving the welfare of X.

2. Knowledge is equally as important as action in achieving the welfare of X (↑↑).

3. Knowledge is utilized to decide the intention and action to be enacted toward X (⟶).

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

Sample

General 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 PTCAs 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 Data

Research 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 (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 Asscssible (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" (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 (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