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Nurse managers' and staff nurses' perceptions of effective caring behaviors

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Nurse managers' and staff nurses' perceptions of effective caring behaviors

Yamamoto, Deanna Sanchez, M.S.

San Jose State University, 1993

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**NURSE MANAGERS' AND STAFF NURSES' PERCEPTIONS
OF EFFECTIVE CARING BEHAVIORS**

A Thesis

Presented to

The Faculty of the Department of Nursing

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

By

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May, 1993

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ABSTRACT

NURSE MANAGERS' AND STAFF NURSES' PERCEPTIONS OF EFFECTIVE CARING BEHAVIORS

by Deanna Sanchez Yamamoto

This thesis explores nurse managers' and staff nurses' ($N=48$) perceptions of effective caring behaviors in an acute care setting. The study employed a descriptive, cross-sectional design using the Larson Care-Q Instrument to obtain data. The participants included nurse managers ($n=13$) and staff nurses ($n=35$).

The significance of the differences between the groups was tested using the Mann-Whitney U Test. Results indicate agreement between the nurse managers and staff nurses on their perceptions of the most important caring behaviors, but not on their perceptions of the least important caring behaviors. Both groups identified the behavioral item "suggests questions for the patient to ask her/his doctor" as an unimportant behavior, however, nurse managers had a tendency to rank this item lower in importance than did the staff nurses. Review of the data provides a better understanding of nurse managers' and staff nurses' perceptions of caring behaviors and gives direction for further research.

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To my husband, Wayne, and children, Adam and Lisa, who
contributed to this thesis by helping
sort hundreds of cards.

TABLE OF CONTENTS

	Page
LIST OF TABLES.....	viii
Chapter	
1. INTRODUCTION.....	1
Background.....	1
Problem.....	2
Purpose.....	3
Research Questions.....	4
Definition of Terms.....	4
Summary.....	5
2. CONCEPTUAL FRAMEWORK AND REVIEW	
OF LITERATURE.....	6
Conceptual Framework.....	6
Review of the Literature.....	9
Summary.....	13
3. METHODS.....	15
Design.....	15
Subjects/Setting.....	15
Human Subjects Approval.....	16

	Page
Risk/Benefits.....	16
Data Collection.....	17
Larson CARE-Q Instrument.....	18
Analysis Procedures.....	20
Summary.....	21
4. ANALYSIS AND INTERPRETATION OF DATA.....	22
Description of the Sample.....	22
Research Question 1.....	26
Research Question 2.....	29
Research Question 3.....	32
Summary.....	34
5. DISCUSSION.....	36
Summary of Study.....	36
Conclusions.....	37
Limitations.....	38
Recommendations.....	40
Summary.....	41
REFERENCES.....	42

	Page
APPENDIXES	
A. Human Subjects Approval.....	47
B. Cover Letter.....	51
C. Consent Form.....	53
D. Demographic Sheet.....	56
E. CARE-Q Instrument.....	58
F. Instruction Sheet.....	69
G. Follow-Up Letter.....	71

LIST OF TABLES

Table	Page
1. Educational Degree of Nurse Managers and Staff Nurses.....	23
2. Area of Nursing Specialty.....	24
3. Years Worked in Nursing for Nurse Managers and Staff Nurses.....	25
4. T-Test Results for Years Worked in Nursing Between Nurse Managers and Staff Nurses.....	26
5. Nurse Managers' Perceptions of the Most Important Nurse Caring Behaviors: The Mean Scores of the Ten Most Important Items.....	27
6. Nurse Managers' Perceptions of the Least Important Nurse Caring Behaviors: Mean Scores of the Ten Least Important Items.....	28
7. Staff Nurses' Perceptions of the Most Important Nurse Caring Behaviors: The Mean Scores of the Ten Most Important Items.....	30
8. Staff Nurses' Perceptions of the Least Important Nurse Caring Behaviors: The Mean Scores of the Ten Least Important Items.....	31

Table		Page
9.	Differences Between Nurse Managers' and Staff Nurses' Ranked Behaviors.....	33

Chapter 1

INTRODUCTION

Background

Recent changes in health care have forced the reduction of many services. Among these services, nursing is always a prime target for budget reductions. In the acute care setting, nursing services are one of the largest expenses. The dilemma the nursing profession faces is how to make nursing budget reductions without sacrificing the quality of patient care or job satisfaction for the staff nurse.

Unfortunately, it is not the direct care giver, the staff nurse, who has the power to make budget reductions. Rather, it is the nurse manager who has the responsibility to determine services provided, and the nurse manager is removed from the bedside and direct patient care. To date, several studies have examined how nurses' and patients' perceptions of care differ. However, the relationship between how staff nurses and nurse managers prioritize nursing behaviors has not been studied. Therefore, this study sought information about how both staff nurses and nurse managers perceive effective nursing care behaviors.

Problem

Before nursing practices can be evaluated for effectiveness, the concept of caring must be defined and the nursing practices which constitute caring must be identified. It is the nurse managers' responsibility to evaluate care and it is the staff nurses' responsibility to provide care, hence, a clear understanding of caring as perceived by these two groups needs to be examined.

Caring is primarily experienced within the practice domain of nursing, and this practice domain centers on nurse-patient interactions (Larson, 1981). To date, several studies have investigated the nurse-patient interaction to determine caring behaviors. These studies found nurses and patients perceived important caring behaviors differently (Larson, 1981, 1984; Mayer, 1987). Patients valued most those nurse caring behaviors which expressed clinical skills and competencies while nurses valued most those actions which expressed psychological support for the patient (Larson, 1981, 1984; Mayer, 1987).

The nurse-patient interaction is not an isolated event, and the time the nurse spends at the bedside is shrinking due to increased paperwork and increased patient assignments (Forrest, 1988). The nurse manager also plays an important role in the determination of the care provided, and must allocate resources which directly relate to patient care in the face of financial constraints, as well as hospital and governmental regulation. Confronted by the possibility of continued cutbacks, it is important to understand the nurse managers' and

staff nurses' perceptions of the most and least effective caring behaviors. A clear understanding of these two perceptions for similarities and differences may be the key to making further reductions in services.

Purpose

The purpose of the research was to explore the perceptions of nurse managers' and staff nurses' effective caring behaviors. The study proposed to identify similarities and differences of these perceptions between staff nurses and nurse managers. In today's economical climate, basic questions need to be asked about the practice of nursing in institutions where nurse managers and staff nurses face the increased focus on efficiency, high technology, and cost-containment.

Nurse managers and staff nurses must identify those behaviors they value the most, because as patient acuity rises and support services are eliminated: staff nurses can no longer be all things to all patients in the course of a single shift. The need for a study which examines nurse caring behaviors is best described by Brenner, Boyd, Thompson, Marz, Buerhaus, and Leininger (1986) as follows:

Watson implores us to remember that caring must have a scientific base and that this foundation must achieve the delicate balance between scientific knowledge and humanistic practice behaviors. Leininger holds that care should be the unique, central, and dominant concept and

metaparadigm of nursing. Theoretical stances and admonitions are not ends in and of themselves. It is essential that theory be used as the basis for generating research that will have practical utility (p. 26).

Discovering what the staff nurses' and nurse managers' perceptions of the least and most effective caring behaviors will help to further define the practice of caring among nurses.

Research Questions

The research questions asked were:

1. What are nurse managers' perceptions of the most and least important care behaviors?
2. What are staff nurses' perceptions of the most and least important care behaviors?
3. Is there a difference between the nurse managers' and staff nurses' perceptions of most and least important care behaviors?

Definition of Terms

In order to make the study operational, key terms were defined as follows:

1. A staff nurse is a working, registered nurse with one or more years' experience within the acute patient care setting.
2. A nurse manager is a registered nurse who directs, oversees, and coordinates the efforts of staff nurses within the patient care setting.

3. Perception of nurse care behaviors was defined as an understanding and ranking of the 50 identified nursing actions as measured by the CARE-Q instrument.

4. Caring behaviors were defined as 50 nurse behaviors identified as being representative of the caring concept of nursing as described and listed by the Care-Q instrument (Larson, 1984). Examples of caring behaviors include: Checks on patient frequently, is honest with the patient about his medical condition, is cheerful, talks to the patient, helps the patient establish realistic goals, is well organized, and knows when to call the doctor.

Summary

The goal of nursing is to care for patients and the measure of this goal is that patients feel cared for by the nurse. In an era when health care faces a refocusing of resources, fundamental questions need to be answered such as what are the most effective behaviors which convey care? How do direct and semidirect care givers rank the importance of these behaviors?

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF LITERATURE

Conceptual Framework

Caring is nursing; however, care itself is not a tangible objective but rather it is a vague concept or idea. Four major nursing models of caring exist and attempt to describe the important components of caring, but there has been minimal testing of the applicability of these models to actual nursing practice (Larson, 1981). These four models are broad attempts to explain caring, and thus, are open to interpretation. Therefore, caring is the framework for this research and the study was conducted on the basis of the following four caring theories.

Gaut (1986) attempts to define the concept of caring as an ordered series of actions. These actions include the nurse identifying the patient's need for care. The nurse then must choose and implement an action based on that knowledge with the intent of bringing about a positive change, and the positive change conditions must be judged solely on the basis of what is generally considered good for the patient.

In the Leininger (1984) model, caring is the central theme in nursing care, nursing knowledge, and practice. Leininger has developed a derived theory from the discipline of anthropology and has conceptualized a caring model to

be relevant to nursing (Marriner, 1986). In this model, care is an essential human need for the full development, health maintenance, and survival of human beings in all world cultures (Leininger, 1984). Caring serves to improve the human condition; via more than 25 major constructs identified by Leininger (1981). The constructs include such ideas as support, presence, touch, empathy, nurturance, compassion, comfort, direct and indirect helping behaviors, enabling, and facilitating (Viale, 1987). Leininger believes that for therapeutic interaction to take place, there must be congruence between the care giver and the care recipients' behaviors and goals (Leininger, 1981).

Watson's model of caring is in part an extension of Leininger's work, and similar to Leininger, Watson views caring as a universal social phenomenon that is only effectively practiced interpersonally (Marriner, 1986). Watson (1985) states:

Human caring is nursing, therefore, is not just an emotion, concern, attitude, or benevolent desire. Caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity. Human caring involves values, a will and a commitment to care, knowledge, caring actions, and consequences. All of human caring is related to intersubjective human responses to health-illness conditions; a knowledge of health-illness, environmental-personal interactions; a

knowledge of the nurse caring process; self-knowledge, knowledge of one's power and transactions limitations (p. 29).

Watson's (1985) model identifies 10 carative factors that the nurse uses as a framework to guide nursing actions. These carative factors are:

1. humanistic and altruistic system of values;
2. faith and hope;
3. sensitivity to self and others;
4. helping and trusting human care relationship;
5. expressing positive and negative feelings;
6. creative problem solving caring process;
7. transpersonal teaching and learning;
8. supportive, protective, and/or corrective mental, physical, societal, and spiritual environment;
9. human needs assistance; and
10. existential and phenomenological spiritual forces (p. 75).

Bevis (1982) also views caring as a process, and that caring is central to nursing. In this model the process of caring is made up of purpose, organization, and creativity. The purpose of caring is growth toward mutual self-actualization. The organization of caring is the system for achieving growth and mutual self-actualization, and the creativity of caring is the unique way in which caring is experienced and reciprocated.

Professional nursing was conceptualized for this study as nursing practices which incorporate the dimensions of care, cure, and coordination (Larson, 1986), and these practices can be identified and ranked in importance. Caring, as conceptualized for this study, permeates the three dimensions through the interactions of nurses with patients (Larson, 1986).

Review of the Literature

Until recently many of the reports on caring in the literature were anecdotal. A review of important research related to caring and the perceptions of caring by the nurse and patient follows.

Brown (1986) studied 50 hospitalized patients attempting to identify nursing behaviors which made the patient feel cared for by the nurse. This qualitative study revealed eight care themes and describes two patterns of combined themes. The first pattern was the demonstration of professional knowledge and skill, surveillance, and reassuring presence. The second pattern was recognition of individual qualities and needs, promoting autonomy, and time spent (Brown, 1986). Like Larson (1984), Brown concludes that nurses cannot assume that a well intentioned nursing act is experienced as care by the patient.

Using a phenomenological approach, Rieman (1986) studied those nursing actions which convey noncaring. Rieman states that patients perceived noncaring behaviors as "being rough and belittling patients" and "treating

patients as objects" (p. 33). However, none of the small sample ($N=10$) in this qualitative study identified poorly performed technical procedures as noncaring. Rieman warns against nurses being praised and rewarded for efficiency, nursing being devalued by physicians and administrators, and nurses being attuned to monitoring the machines rather than to the patients attached to these machines.

Larson's work on caring is extensive; however, it only focuses on the nurse-patient relationship, with the earliest work identifying the patients' perceptions. Larson (1984) studied the perceptions of patients with cancer ($N=57$) identifying the most important nurse caring behaviors. She used a convenience sample of hospitalized patients from three acute care hospitals. The Caring Assessment Instrument (CARE-Q) was used to obtain the patients' perceptions on nursing caring behaviors. This tool consists of 50 behavioral items ordered in six subscales. These subscales are: (a) accessible, (b) explains and facilitates, (c) comforts, (d) anticipates, (e) trusting relationship, and (f) monitors and follows through. The 50 behavioral items are ranked by importance (Larson, 1984). In this study patients ranked as most important those behaviors which reflected clinical competency. Additionally, patients ranked lowest psychosocial behaviors which are highly valued by nurses (Larson, 1984).

To further this preliminary work, Larson (1987) studied both cancer patients' ($n=57$) and nurses' ($n=57$) perceptions for the most important nurse caring behaviors. Data obtained were significant ($p<.05$), using a t -test in 19 out of 50 behaviors using the CARE-Q instrument. Again, Larson found patients perceived "being accessible" and "monitoring and following through" as the most important nurse caring behaviors. The top five behaviors patients ranked as most important were: (a) knows how to give shots, (b) knows when to call physician, (c) gives good physical care to patient, (d) gives patients treatments and (e) medications on time, and checks on patient frequently. In contrast, trusting relationship and comfort subscales were ranked significantly higher by the nurses. Larson concludes that nurses must not assume that intended caring is always perceived as such by the patient, and that nurse behaviors which demonstrated clinical skill and knowledge were important signals of caring for the patient.

The Larson study was replicated by Mayer (1987) using a convenience sample of 54 cancer patients and 28 oncology nurses. Mayer used the CARE-Q instrument designed by Larson. The Mayer study demonstrated similar data results to Larson, with 100% agreement between the two nurse groups of the most and least important caring behaviors. However, there was only a 40% agreement between the two patient groups of the most important caring behaviors, and 80% agreement of the least important caring behaviors. The

least important nurse caring behaviors for the nurse included: "is professional in appearance--wears appropriate identifiable clothing and identification," "suggests questions for the patient to ask the doctor," and "is cheerful." For the patient the least important nurse caring behaviors included: "ask the patient what name he/she prefers to be called," "is professional in appearance . . . ," and "checks out with the patient the best time to talk with the patient about changes in his/her condition" (Mayer, 1987). Finally, the correlation of the six mean categories between Mayer's and Larson's patients was $r = .87$, $p = .025$, and between the nurses in the same groups $r = .66$, $p = .16$ (Mayer, 1987).

More recently, Mangold (1991) used a convenience sample of senior baccalaureate nursing students ($n = 30$) and professional nurses ($n = 30$) using the CARE-Q instrument to determine their perceptions of effective care behaviors and to identify areas of agreement and disagreement between the two groups. The sum of the ranks for both groups for each subscale were compared by calculating the Mann Whitney U statistic and no significant difference between the groups was found. Mangold's results supports the research previously conducted by Mayer (1987) and Larson (1987).

Nori, Doehring, and Hirschert (1991), using the CARE-Q instrument, studied nurses with advanced education to determine their perception of effective caring behaviors. The convenience sample ($N = 110$) consisted of 13 nurse managers, 72 educators, and 23 practitioners/clinical specialists. The

findings of the study supported the findings of previous studies in that the study's subjects had a tendency to rank comfort and trusting relationships items as most important.

In Forrest's (1988) qualitative study investigating the phenomenon of caring with 17 hospital staff nurses, the staff nurses' perceptions of how the nurse manager affects their role and patient care are briefly addressed. Forrest found staff nurses described nurse administrators as: out of touch with patient care, nurse administrators advocate patient classification system that dehumanizes, a lack of positive acknowledgement, and little recognition of the nurse's individuality. The limitation of this study is the small sample size of 17 from one hospital. Therefore, wider generalization of the study may not be valid.

Summary

Caring theories offer a framework to study caring and Larson's instrument, the CARE-Q, offers a tool to measure caring behaviors. In an era of hospital cost containment, further research in the area of the perceptions of nurse managers and staff nurses is needed to assure that appropriate reductions of nursing care are done without sacrificing quality patient care and job satisfaction for the staff nurse.

Forrest's (1988) work implies that nurse administrators and managers affect the staff nurses' experience of caring, but none of the current research

addresses this relationship. The research clearly indicates that patients perceive effective caring behaviors differently from nurses, but no research exists on the differences, if any, between nurse managers' and staff nurses' perceptions of effective caring behaviors.

Chapter 3

METHODS

Design

This study employs a descriptive, cross-sectional design using the Larson CARE-Q instrument. The CARE-Q instrument has been developed for use with the Q methodology. The specific purpose of the instrument is to identify the nurse caring behaviors that are perceived as important in making patients feel cared for by the nurse.

Subjects/Setting

One hundred research tools were sent to 80 staff nurses and 20 nurse managers currently employed at a large acute care hospital. Nurse managers returned 13 completed tools and 35 completed tools were returned by the staff nurses. The hospital's total bed capacity was 345 and employed over 700 registered nurses (D. Allen, personal communication, November 20, 1991). The subjects were conveniently selected. All nurse managers listed in the hospital directory as an inpatient Nurse Manager, Assistant Director of Nurses, and Director of Nurses were asked to participate in the study.

A random sample of 10% of the total registered nursing staff employed in the inpatient setting also were asked to participate in this study. A total of 80 nurses, 20, from Critical Care, Medical/Surgical, Maternal Child Health, and

Rehabilitation Nursing Specialties, were randomly selected for the study. A master list of registered nurses employed at the hospital was obtained from the nursing office. The first 20 names appearing in alphabetical order for each of the four specialties constituted the staff nurse sample. Each staff nurse met the following criteria to be eligible for inclusion in the study:

1. Perform direct inpatient care as their primary job responsibility.
2. Have at least one or more years of nursing experience.
3. Return a signed consent form.
4. Assistant head nurses, staff developers, and clinical nurse specialists

were not eligible to participate in the study.

Human Subjects Approval

This study was approved by both the Human Subjects-Institutional Review Board at San Jose State University, September, 1992, and the participating institution's Research and Human Subjects Review Committee, August, 1992 (Appendix A). Subjects were instructed to contact the research committee at the medical center or Serena Stanford, Ph.D., Vice President of Graduate Studies and Research at San Jose State University for questions or complaints about the study.

Risk/Benefits

There was no direct benefit to subjects for participation in the research study other than contributing to the general body of nursing knowledge, and

being given an opportunity to have input as to what they felt were the most and least effective caring behaviors of nurses. The study involved minimal risk to the subjects. Names of subjects were kept confidential and anonymous, therefore, their participation did not jeopardize their employment, and the subject could withdraw from the study at any time.

Data Collection

One hundred research packets in 10x12 envelopes were assembled containing the following: (a) cover letter addressed with subject's first name, (b) consent form, (c) demographic sheet, (d) CARE-Q Instrument, (e) instruction sheet, and (f) return 10x12 envelope (Appendixes B, C, D, E, and F). The CARE-Q instrument consisted of the 50 nurse caring behaviors, preprinted on 3x5 cards and 7 library card pockets each labeled as follows: (a) most important, (b) fairly important, (c) neither important or unimportant, (d) somewhat unimportant, (e) unimportant, and (f) not important with the corresponding number of cards to be placed in each one. The awkwardness of the CARE-Q instrument precludes its attachment to the appendixes; however, Appendix E has a full description of the tool including all 50 behaviors. Preprinted labels with the researcher's name and department were placed on return envelopes and along with the research articles placed in the 10x12 envelopes and addressed to the 100 subjects. The envelopes were then

distributed to the subjects via the hospital mail system. The subjects were not contacted directly unless they telephoned with questions.

The subjects were given 1 week to sign and return the consent form, along with the completed demographic sheet and CARE-Q instrument via the hospital mail system. The demographic data sheet requested information about each subject's age, education, work experience, and nursing experience. Twenty days following the mailing of the research packets, a follow-up letter was sent to all 100 subjects requesting that they return a completed instrument, demographic sheet, and signed consent form (Appendix G) if they had not already done so.

Larson Care-Q Instrument

Development

This research project employed the Q methodology. This methodology provides diversity of individual perception in an objective manner and aids in the identification of the most and least important items of a scale by the use of a forced-choice quasi-normal distribution (Mangold, 1991).

Permission was obtained to use the Caring Assessment Instrument (CARE-Q) designed by Patricia J. Larson, R.N., D.N.S. (Appendix E). The instrument was developed on the premise that enacted nurse caring behaviors produce a sense of "feeling cared for" in patients (P. J. Larson, personal communication, March 4, 1992).

The development of the CARE-Q instrument required two major phases. Phase I was the identification of nurse caring behaviors through two preliminary studies; one with nurses and another with patients to determine nurse behaviors that convey a sense of caring. Sixty-nine nurse behaviors were identified and were labeled as "nurse caring behaviors." Themes of caring evolved from a patient study and were retained as scale categories for the instrument (P. J. Larson, personal communication, March 4, 1992). Phase II of the instrument development involved the validity and reliability testing.

Validity

Face and content validity of the CARE-Q instrument has been established via two review panels of nurse experts. Construct validity has not been established due to lack of similar instruments (Mangold, 1991). The resulting instrument consists of 50 nurse caring behavioral items and 6 caring themes. The CARE-Q instrument is designed for use with Q methodology to gain perceptions, by ranked order, of important nurse caring behaviors. The forced choice distributions require participants to select predetermined number of items for each of the most important to least important categories.

The 50 behavior items are ordered in six subscales of caring as follows:

Accessible (6 items)

Explains and Facilitates (6 items)

Comforts (9 items)

Anticipates (5 items)

Trusting Relationship (16 items)

Monitors and Follows Through (8 items)

Each subject sorts 50 CARE-Q cards, identifying 50 nurse care behaviors, into 7 different packets. Each placing only 1 item as the most important, 4 items as fairly important; 10 items as somewhat important; 20 items neither important nor unimportant; 10 items as somewhat unimportant; 4 items as unimportant, and 1 item not important.

Reliability

The reliability of the CARE-Q instrument was conducted with two test-retest studies with nurses. The first ($N=9$) revealed a perfect correlation between Test I and Test II on the items selected as most important and least important. The second test-retest CARE-Q study ($N=82$) revealed the item ranking consistency of the CARE-Q items ranked as most important (the top 5) to be 79.1% between Test I and Test II. For the least important ranked items (the bottom 5), the consistency ratio was 63.4% (P. J. Larson, personal communication, March 4, 1992).

Analysis Procedures

The statistical test used to analyze the ordinal data from the Larson CARE-Q instrument is the Mann-Whitney U test (Mangold, 1991). The

Mann-Whitney U test is used because it tests whether there is a significant difference between two independent samples, and because it can be used with two samples of unequal number. Since the Mann-Whitney U test is a more powerful test than the Median test, it is better as a nonparametric alternative to the t-test (Huck, Cormier, & Bounds, 1974).

Summary

Utilizing the CARE-Q Instrument, 100 tools were sent to 100 nurses; 80 staff nurses and 20 nurse managers. Nurse managers returned 13 completed tools and the staff nurses returned 35 completed tools. The research tool employs a forced-choice quasi-normal distribution for the identification of the most and least important behavior items. Final analysis of the data was done with the Mann-Whitney U Test to determine significant differences between the two groups.

Chapter 4

ANALYSIS AND INTERPRETATION OF DATA

Description of the Sample

Of the 100 CARE-Q instruments sent to 20 nurse managers and 80 staff nurses, there was a 65% return rate for nurse managers ($n=13$) and a 44% return rate for staff nurses ($n=35$). The demographic information collected are reported as descriptive data in addition to the results of the CARE-Q instrument for the three research questions asked. These research questions were:

1. What are nurse managers' perceptions of the most and least important care behaviors?
2. What are staff nurses' perceptions of the most and least important care behaviors?
3. Is there a difference between the nurse managers' and staff nurses' perceptions of most and least important care behaviors?

The demographic data collected gives a general background of subjects participating in the research and are reported as follows for educational degree, specialty, and years worked in nursing. Table 1 is a summary of the educational degrees reported by both the nurse managers and staff nurses participating in the study. Only one staff nurse reported having an advanced degree while the remaining staff nurses reported: (a) five diploma degrees (DP),

(b) 10 associate degrees (AD), and (c) 19 bachelor of science degrees (BSN). In comparison, the nurse managers reported the following: (a) one diploma degree, (b) two associate degrees, (c) four bachelor of science degrees, and (d) six advanced degrees.

Table 1

Educational Degree of Nurse Managers and Staff Nurses.

	DP	AD	BSN	MS	MSN	MPA
Nurse Manager (<u>n</u> =13)	1	2	4	2	2	2
Staff Nurse (<u>n</u> =35)	5	10	19	1		

Table 2 presents the number of nurses in the four areas of nursing specialty: (a) critical care, (b) medical/surgical, (c) maternal child health, and (d) rehabilitation. The number of nurse managers from each area were: (a) four from critical care, (b) four from maternal child health, (c) three from medical/surgical, (d) none from rehabilitation, and (e) two did not indicate area of specialty. The staff nurses' areas of specialty were: (a) 11 from medical/surgical, (b) 10 from maternal child health, (c) six from rehabilitation, (d) seven from critical care, and (e) only one did not report an area of nursing specialty. Of the areas of nursing specialty, only rehabilitation was not equally represented by the participants (N=48). Only 13% of the participants (n=6)

were from rehabilitation as compared to 23% from critical care ($n=11$), 29% from maternal child health ($n=14$), and 29% from medical/surgical ($n=14$). Six percent of participants ($n=3$) did not report an area of nursing specialty.

Table 2

Area of Nursing Specialty.

Area	Manager	Staff
Critical Care	4	7
Medical/Surgical	3	11
Maternal Child Health	4	10
Rehabilitation		6
Area not reported	2	1

Table 3 reports the years worked in nursing for the nurse managers which ranged from 14 to 36 and one to 36 for the staff nurses. The mean years worked in nursing for nurse managers was 21.23 and for staff nurses the mean for years worked in nursing was 13.17. Table 4 shows there was a significant difference in the years worked in nursing between the managers and staff ($p=.0028$).

The descriptive data from the demographic information shows that nurse managers as compared to the staff nurses have more advanced degrees and have worked more years in nursing. Of the four nursing specialties only rehabilitation was underrepresented. There was a significant difference in mean

scores for years worked in nursing between the nurse managers and staff nurses. As expected, the nurse managers had the greater number of years in nursing.

Table 3

Years Worked in Nursing for Nurse Managers and Staff Nurses.

Years	Managers <u>n</u> = 13	Staff <u>n</u> = 35
1		2
2		1
3		2
5		2
6		1
8		1
9		1
10		5
11		1
12		3
13		1
14	1	
15		3
16	1	2
17	3	1
18	1	
19	1	2
20	1	3
22	3	
24		1
26		1
30		1
36	2	1

Table 4

T-Test Results for Years Worked in Nursing Between Nurse Managers and Staff Nurses (N=48).

Group	<u>M</u>	<u>SD</u>	<u>T-Score</u>	<u>P-Values</u>
Nurse Managers (n=13)	21.23	7.00	3.16	.0028
Staff Nurses (n=35)	13.17	8.13		

Research Question 1

To answer the first research question: "What are nurse managers' perceptions of the most and least important care behaviors?," the data was ranked from one for the most important, to seven as the least important, and the means of the 50 CARE-Q items were then calculated. Table 5 reports the distribution of caring behaviors. The mean scores ranged from 2.62 for the most important item, "Knows when to call the doctor," to 5.54 for the least important item, "Suggests questions for the patient to ask his/her doctor. . .". Two of the ten highest items ranked as most important were in the subscale, Monitors and Follows Through, two were in the subscale Trusting Relationship, two in the subscale of Comforts, and four in the Accessible subscale.

Table 5

Nurse Managers' Perceptions of the Most Important Nurse Caring Behaviors: The Mean Scores of the Ten Most Important Items.

CARE-Q Subscale	CARE-Q Item*	<u>M</u>	<u>SD</u>
Monitors & Follows Through	Knows when to call doctor	2.62	0.65
Comforts	Listens to patient	2.62	1.26
Monitors & Follows Through	Gives good physical care to patient	2.85	0.90
Trusting Relationship	Realizes patient knows himself...	3.08	0.95
Accessible	Gives patient's treatment and medication on time	3.23	1.17
Trusting Relationship	Introduces self and tells patient what she/he does	3.23	1.36
Comforts	Talks to patient	3.31	0.95
Accessible	Quick response to patient's call	3.39	1.04
Accessible	Checks on patient frequently	3.69	1.03
Accessible	Encourages patient to call if she/he has problems	3.77	0.73

*For complete description of behavior, see Appendix D.

Note: Coding of items; 1 = most important, 7 = least important

The ten least important caring behaviors are shown in Table 6. The largest number of behaviors ranked as least important are five in the subscale of Trusting Relationships, followed by three in the subscale of Explains and

Table 6

Nurse Managers' Perceptions of the Least Important Nurse Caring Behaviors: The Mean Scores of the Ten Least Important Items.

CARE-Q Subscale	CARE-Q Item*	<u>M</u>	<u>SD</u>
Explains and Facilitates	Suggests questions for patient to ask doctor	5.54	1.05
Accessible	Volunteers to do "little" things. . .	5.30	1.25
Trusting Relationship	Checks with patient what time is best to talk about changes in his/her condition	5.08	0.76
Anticipates	Realizes that nights are a difficult time for patients	5.00	0.91
Trusting Relationship	Gets to know patient as individual	5.00	0.82
Trusting Relationship	Continues to be interested in the patient. . .	4.84	0.80
Trusting Relationship	Helps patient clarify thinking in regard to disease and treatments	4.85	0.90
Explains and Facilitates	Tells patient of support systems available	4.77	1.24
Explains and Facilitates	Helps patient not feel dumb by giving adequate information	4.77	0.93
Trusting Relationship	When with a patient, concentrates on that patient	4.70	1.31

*For complete description of behavior, see Appendix D.

Note: Coding of items; 1 = most important, 7 = least important

Facilitates, one in the subscale of Accessible, and one in the subscale of Anticipates.

Nurse managers appear to value most those nursing caring behaviors that communicate accessibility and value least those behaviors that communicate the development of a trusting relationship. These values may be instilled into first line managers who are concerned with efficiency and productivity which may lead to conflict if the staff nurses do not share the same values.

Research Question 2

The second research question asked: "What are staff nurses' perception of the most and least important care behavior?" Data were analyzed in the same manner as for the nurse managers. Table 7 is a summary of the data for the most important nurse caring behaviors. The resulting data ranged from mean scores of 2.69 for the most important item, "Listens to the patient," to a mean score of 4.86 for the least important item, "Gets to know the patient as an individual person." Four of the top ten ranked as most important were in the subscale Monitors and Follows Through, two in the subscale Trusting Relationship, and one caring behavior in the subscales of Comforts, Accessible, and Explains and Facilitates.

Table 7

Staff Nurses' Perceptions of the Most Important Nurse Caring Behaviors: The Mean Scores of the Ten Most Important Items.

CARE-Q Subscale	CARE-Q Item*	<u>M</u>	<u>SD</u>
Comforts	Listens to patient	2.69	1.02
Monitors and Follows Through	Knows when to call doctor	2.74	1.22
Monitors and Follows Through	Knows how to give shots...	2.86	0.94
Monitors and Follows Through	Is well organized	3.09	1.15
Accessible	Gives patient's treatments and medications on time	3.09	0.95
Anticipates	Is perceptive of patient's needs and plans/acts accordingly	3.20	0.90
Trusting Relationship	Allows patient to express feelings	3.43	0.82
Monitors and Follows Through	Is calm	3.51	1.04
Explains and Facilitates	Teaches patient how to care for himself/herself...	3.54	0.89
Trusting Relationship	Is pleasant and friendly...	4.37	0.88

*For complete description of behavior, see Appendix D.

Note: Coding of items; 1 = most important, 7 = least important

Table 8 is a summary of the least important nurse caring behaviors ranked by the staff nurses. These least important behaviors were: six in the subscale of Trusting Relationship; two in the Comforts subscale; and one behavior for the subscales Explains and Facilitates and Anticipates.

Table 8

Staff Nurses' Perceptions of the Least Important Nurse Caring Behaviors: The Mean Scores of the Ten Least Important Items.

CARE-Q Subscale	CARE-Q Item*	<u>M</u>	<u>SD</u>
Trusting Relationship	Gets to know patient as individual	4.86	1.12
Comforts	Sits down with patient	4.80	0.83
Trusting Relationship	When with a patient, concentrates on that patient	4.74	1.17
Explains and Facilitates	Suggests questions for patients to ask doctor	4.69	0.90
Trusting Relationship	Checks with patient what time is best to talk about changes in his/her condition	4.66	1.08
Trust Relationship	Asks patient what name he/she prefers to be called	4.66	1.08
Anticipates	Realizes that nights are a difficult time for patients	4.63	1.14
Trusting Relationship	Offers alternatives to patient	4.57	1.01
Comforts	Is cheerful	4.57	1.17
Trusting Relationship	Helps patient clarify thinking in regard to disease...	4.57	0.92

*For complete description of behavior, see Appendix D.

Note: Coding of items; 1 = most important, 7 = least important

Nurse managers and staff nurses ranked the most important caring behaviors differently. Nurse managers had the majority of the most important behaviors in the Accessible subscale, whereas staff nurses had the majority in the Monitors and Follows Through subscale. However, the majority of the least important caring behaviors for nurse managers and staff nurses were in the Trusting Relationship subscale. This data leads to the final research question.

Research Question 3

"Is there a difference between the nurse managers' and staff nurses' perceptions of most and least important care behaviors?" To determine if there was a difference between the two groups, each of the 50 behavioral items for the nurse managers and staff nurses were ranked and the sum of the ranks compared by calculating the Mann Whitney U statistic. The scores for each of the 50 behaviors along with resulting z- and p-values were tabulated. Table 9 is a summary of the significant behaviors. At a $p < .05$ significance level, 7 out of 50 behaviors were statistically significant for differences between the two groups. Only five of the seven significant behaviors fell within the reported mean scores of the ten most and least important behaviors for the nurse managers and staff nurses.

Of the five statistically significant differences in behaviors between the nurse manager group and staff nurse group, three were in the Trusting Relationship subscale, one in the Accessible subscale, and one in the Explains

Table 9

Differences Between Nurse Managers' and Staff Nurses' Ranked Behaviors.

CARE-Q Subscale	CARE-Q Item	Nurse Managers (n=13)	Staff Nurses (n=35)	z Value	p Value (p<.05)
Accessible	Volunteers to do "little" things, etc.	34.19 (LI)	20.90	3.03	.00
Explains and Facilitates	Suggests questions for patient to ask his/her doctor	31.96 (LI)	21.73 (LI)	2.38	.01
Trusting Relationship	Offers reasonable alternatives to the patient, etc.	17.61	27.06 (LI)	2.21	.03
Trusting Relationship	Is pleasant and friendly to patient's family and significant others.	17.54	27.09 (MI)	2.34	.02
Trusting Relationship	Asks the patient what name he/she prefers to be called.	18.35	26.79 (LI)	2.05	.04

Note: MI = Most Important, LI = Least Important

and Facilitates subscale. Of the three behaviors in the Trusting Relationship subscale, two were ranked least important and one as a most important caring behavior by the staff nurses. Even though the overall indication from both groups was that the Trusting Relationship behaviors were least important, there is a difference in the value of these three behaviors between the two groups.

For the two groups, the statistically significant difference in behavior in the Accessible subscale, "Volunteers to do little things," was ranked as a least important behavior by the nurse managers, but not the staff nurses. The behavioral item "Volunteers to do little things," was not identified by the staff nurses as a significant item for either being important or unimportant caring behaviors.

The last statistically significant difference in behavior was in the subscale of Explains and Facilitates, "Suggests questions for the patient to ask her/his doctor." Both groups ranked this behavior as least important. The only conclusion that can be drawn is that each group felt this behavior to be unimportant at different degrees.

Summary

Using the CARE-Q instrument, the most important and least important nurse caring behaviors were identified for nurse managers and staff nurses ($N=48$). These behaviors were further divided into one of six subscales and the ten behavioral items ranked as the most important and least important for each

group were compared for differences. This was accomplished by calculating the Mann Whitney U statistic along with the resulting z and p values. Only five behaviors were significantly different at a $p < .05$ level. Four of the five significantly different behaviors were in the least important caring behavior category. Nurse managers' and staff nurses' perceptions of the most important caring behaviors are in agreement; however, what these two groups perceive as the least important behaviors are not in agreement.

Chapter 5

DISCUSSION

Summary of Study

This study explored nurse managers' and staff nurses' perceptions of effective caring behaviors in an acute care setting. The study proposed to identify similarities and differences in these perceptions. As the practice of nursing in institutions is being redefined to focus on efficiency, high technology, and cost-containment, it becomes essential to have a clear understanding of what these two groups value.

The CARE-Q instrument was employed for this study. The resulting nurse managers' ($n=13$) rankings and staff nurses' ($n=35$) rankings of 50 caring behaviors were summed and mean scores and standard deviations computed for each group. The mean scores of the ten most and least important behavioral items for each group were then compared by utilizing the Mann-Whitney U Test. The resulting z - and p -values identified five significantly different behaviors. The nurse managers' and staff nurses' perceptions of the most important caring behaviors were similar. However, how the groups ranked unimportant behaviors were dissimilar. Overall, both groups perceived those behaviors which foster a trusting relationship as least important but at statistically significant different degrees.

Conclusions

Overall, the nurse managers' and staff nurses' perceptions of caring behaviors in this study were consistent with previous studies. The behavior ranked as most important by both groups was "Listens to the patient." This behavior has been identified as most important in several other studies. These studies include the work of Larson (1986), Mayer (1987), Nori, Doehring, and Hirchert (1991), and Mangold (1991).

Nurse managers and staff nurses in this study perceived least important care behaviors somewhat differently. They tended to rank behaviors in the Trust Relationship subscale of the CARE-Q instrument similarly as least important, but disagreed at a significant level on what trusting behaviors they valued less. Given there was a significant difference between the number of years worked in nursing for both nurse managers and staff nurses, the data were not conclusive enough to account for the difference in rankings. The nurse managers and staff nurses also disagreed on two other least important behaviors, "Volunteers to do 'little' things" and "Suggests questions for the patient to ask."

Further detailed analysis of how the subjects' educational degree, nursing area of specialty, and years worked in nursing influenced the responses from the CARE-Q instrument were beyond the scope of this research project and the subject of other reported studies. Nori, Doehring, and Hirchert (1991),

and examined the significance of educational degree and age differences of their subjects. Additionally, Larson (1986) did not find any evidence that demographic variables had any effect on ranking by nurses using the CARE-Q instrument.

The implications of this research are twofold. First, with financial resources shrinking, it is encouraging to find agreement among what the nurse managers and staff nurses perceive as the most important caring behaviors. These shared perceptions will ensure congruency in these matters. The second implication of this research is that there is a difference in what nurse managers and staff nurses perceive as the least important behaviors. These differences have practical implications because these behaviors are at risk of being devalued as nursing behavior is redefined to focus on efficiency, high technology, and cost-containment. If there cannot be agreement on what behaviors are least important, then there will be ambiguity and friction between nurse managers and staff nurses. This is the first study to examine these two groups, nurse managers and staff nurses, using the CARE-Q instrument to identify caring behaviors.

Limitations

Caring is an abstract concept and difficult, if not impossible, to quantify or test empirically. Currently there are no other tools to measure caring other than the CARE-Q instrument. Unfortunately, the CARE-Q instrument has an

than the CARE-Q instrument. Unfortunately, the CARE-Q instrument has an uneven distribution of the 50 behavioral items into the six subscales of caring. This may have influenced the statistical analysis due to the fact the greatest number of behaviors are in the Trusting subscale.

The actual number of statistical significant behaviors was 7 out of 50 when the nurse managers and staff nurses were compared. These seven behaviors are a relatively small percentage (1.4%) of the total number of behaviors. An agreement could be made that these few behaviors, although statistically significant, do not indicate a sufficient difference between the nurse managers' and staff nurses' perceptions of caring behaviors.

Additional limitations of the study include the small convenience sample of the nurse managers, the setting, and self-reporting. Self-reporting, although subject to error, was the only means by which to gather data using the CARE-Q instrument. Due to the available number of nurse managers, no attempt at randomization of this sample was possible. Using only nurse managers and staff nurses from one acute care setting limits the generalization of the results to other hospitals and patient care settings due to the difference in staffing patterns and philosophies.

The final limitation of this study was the low return rate from the rehabilitation nursing specialty. Six CARE-Q tools were returned from the staff nurses and none were received from the nurse managers. Nurse managers

may have selected not to report their area of nursing specialty for several reasons. First, the nurse managers may have been concerned that their anonymity may have been jeopardized if they indicated their area of specialty. Second, several of the nurse managers have the responsibility for more than one area.

Recommendations

This study focused only on the nurse managers and staff nurses and did not include patients. The premise of this research was to discover the perceptions of the nurses for similarities and differences, but a more comprehensive approach would be to include patients. After all, it is the patient who received the care examined in this study.

An additional recommendation would be to expand this study to include several other acute care and home care settings. Increasing the number of subjects would then allow for randomization. The final recommendations are in regards to the CARE-Q instrument. The instrument should be adjusted to provide a better balance of the distribution of the 50 behavioral items in the six subscales of caring. Sixteen of the behavioral items are in the Trusting subscale, while between five and nine items are in each of the remaining five subscales. A more even distribution could be accomplished if an equal number of behavioral items were in each of the six subscales of caring. The use or development of another instrument to improve the validity of the CARE-Q

develop a more inclusive description of each group's concept of caring behaviors.

Summary

The findings provide direction for additional research and in part support research already conducted. Nurse managers and staff nurses share similar perceptions on the most important caring behaviors. However, these two groups had dissimilar perceptions on the least important caring behaviors. To validate these findings, further refinement of the CARE-Q instrument is recommended in addition to expanding the number of subjects and settings.

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APPENDIXES

APPENDIX A
Human Subjects Approval

Santa Clara Valley Medical Center
751 South Bascom Avenue
San Jose, California 95128
(408) 299-5100

September 1, 1992

Deanna Yamamoto, RN
Department of Nursing
Santa Clara Valley Medical Center
751 South Bascom Avenue
San Jose, CA 95128

RE: Project entitled "Nurse Manager's and Staff Nurses' Perception of Effective Caring Behaviors"

Dear Ms. Yamamoto:

On August 28, 1992, the Research and Human Subjects Review Committee of Santa Clara Valley Medical Center approved the above project.

NOTE: This approval does not constitute a commitment of SCVMC space, funds, or employee time and services. All related matters must be discussed with hospital administration and resolved prior to commencing this project by contacting Mr. Edward Petrillo at 408/299-5333.

In accordance with federal regulations and Committee policy, no changes may be made in the protocol or approved version of the subject's consent form without the knowledge and prior approval of the Committee. All problems having to do with subject safety must be reported to the Committee within five (5) working days.

The approval number assigned to this project is 8/28/92-05. In correspondence concerning this project, it would be helpful if you would refer to this number.

All continuing projects and activities must be reviewed and reapproved at least annually by the Committee. If this project is to continue beyond the expiration date of August 27, 1993, it must be renewed in accordance with the Committee's renewal instructions. As a courtesy reminder, a renewal application will be mailed to you approximately two months prior to the expiration date. Failure to submit an update within 30 days following the due date will result in termination of your approval. If the project is terminated/completed prior to the expiration date, you should immediately notify the Committee in writing. At the completion of the study, please provide a final report of the outcome.

Deanna Yamamoto, RN
Page 2
September 1, 1992

Should you have any questions, please contact the Administrator of the Committee,
Carole Guthrie, at 408/299-6276.

Sincerely,

A handwritten signature in cursive script, reading "Elisabeth A. Mailhot, M.D.", followed by a flourish.

Elisabeth A. Mailhot, M.D., Chair
Research and Human Subjects Review Committee

EAM/cg

cc: Edward Petrillo

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

To: Deanna Yamamoto, Nursing
982 Glenridge Drive
San Jose, CA 95136

From: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies and Research

Date: May 15, 1992

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"The Nurse Managers' and Staff Nurses' Perceptions of Effective Caring Behaviors"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have questions, please contact me at 408-924-2480.

APPENDIX B

Cover Letter

Appendix B
COVER LETTER

Dear: _____

My name is Deanna Yamamoto. I am a graduate student in nursing at San Jose State University. As part of my requirement for a Masters Degree in Science, I am conducting research to find out what staff nurses and nurse managers perceive to be effective nurse caring behaviors. Knowing what nurses and managers perceive as caring behaviors will help understand what caring behaviors are most valued by the nursing profession.

If you are interested in participating, I ask that you complete the CARE-Q instrument (instructions enclosed), demographic data sheet, sign the consent form, and return these items to me in the stamped return envelope by _____.

Since the purpose of this study is to find out what you feel are effective nurse caring behaviors, there are no right or wrong answers.

Thank you for participating in this research project.

Sincerely,

Deanna Yamamoto, R.N.,
Graduate Student
San Jose State University

APPENDIX C
Consent Form

Page 1 of 2

Santa Clara Valley Medical Center

SUBJECT'S CONSENT FORM

TITLE OF STUDY: Nurse Managers and Staff Nurses' Perception of Effective Caring Behaviors

PRINCIPAL INVESTIGATOR: Deanna Yamamoto, R.N., Department of Nursing, Santa Clara Valley Medical Center, 751 South Bascom Avenue, San Jose, California 95128.
Phone: (408) 299-5322.

PURPOSE: You are being asked to participate in this research study investigating nurse caring behaviors because you are a nurse or nurse manager employed at Santa Clara Valley Medical Center. The result of this study will contribute to our understanding of the most and least effective nurse caring behaviors as perceived by the nurse managers and staff nurses. This study is being conducted as part of the requirements for a degree in Master of Science from San Jose State University.

PROCEDURE: If you participate in this study you will need to complete both the demographic data sheet and the CARE-Q instrument and return them along with this consent form in the enclosed envelope.

The demographic data sheet will require no more than several minutes to complete.

The CARE-Q instrument consists of 50 three by five cards containing different nurse care behaviors which you must sort into seven different pockets ranking the behaviors from least important to most important. It will take approximately 20-30 minutes to complete the CARE-Q instrument.

RISK/DISCOMFORTS: There are no risks associated with your participation in this study. Should you feel uncomfortable about the questions asked, you may leave them unanswered or contact Deanna Yamamoto, RN, at 299-5322 for clarification.

BENEFITS: WE CANNOT AND DO NOT GUARANTEE OR PROMISE THAT YOU WILL RECEIVE ANY BENEFITS FROM PARTICIPATING IN THIS STUDY. However, by participating in this study you will be given an opportunity to have input as to what you feel are the most and least effective nurse caring behaviors.

ALTERNATIVES: The alternative to participating in this study is to choose not to participate.

Page 2 of 2

COMPENSATION FOR PARTICIPATION: Participation in this study is voluntary. There is no compensation or cost to you.

CONFIDENTIALITY: The result from this study may be published, but any information from this study that can be identified with your name will remain confidential.

WITHDRAWAL FROM THE STUDY: Participation is voluntary; refusal to participate will not affect your present or future employment at Santa Clara Valley Medical Center. If you decide to participate, you are free to withdraw from the study at any time.

If any new information develops during the course of this study that may affect your participation, you will be informed immediately.

OFFER TO ANSWER QUESTIONS: If you have any question about the study, please feel free to contact Deanna Yamamoto, RN, at 299-5322.

If you have any questions concerning your rights as a research subject, you may contact the Research Committee which is concerned with protection of volunteers in research projects. The Committee may be reached by calling the office from 9:00 a.m. to 5:00 p.m., Monday through Friday at (408) 299-6276, or by writing to the Research Committee, Santa Clara Valley Medical Center, Professional Group, Office Annex Building, Room 127, 751 South Bascom Avenue, San Jose, California 95128. This study is being conducted in conjunction with San Jose State University and questions or complaints about research, subjects' rights, or research-related injury may also be presented to Serena Stanford, Ph.D., Vice President of Graduate Studies and Research, at (408) 924-2480.

WITNESSING AND SIGNATURES: You are voluntarily making a decision whether or not to participate in a research study. Your signature certifies that you have had an adequate opportunity to discuss this study with the investigator and you have had all your questions answered to your satisfaction. You need to make a copy of the signed and dated consent form to keep.

Signature of Subject

Date Signed

IRB Approval # 8/28/92 - 05
Study Approved: 8/28/92

APPENDIX D
Demographic Sheet

Appendix D
Demographic Data

(Please fill in or check appropriate box)

1. Years worked in Nursing: _____
2. Nursing area of Specialty: _____
3. Educational Degree in Nursing:
Dipl. _____ AD _____ BSN _____ MSN _____ Ph.D. _____
4. Age: _____
5. Staff Nurse _____ Nurse Manager _____
6. Working Full Time _____ Part Time _____
7. Shift _____

APPENDIX E
Care-Q Instrument

School of Nursing
Department of Physiological
Nursing, N 611Y, Box 0610
San Francisco, CA 94143

University of California, San Francisco A Health Sciences Campus

March 4, 1992

Deanna Yamamoto, RN, BSN
751 South Bascom Avenue
San Jose, CA 95128

Dear Ms. Yamamoto:

Thank you for your interest in my work on caring. I am enclosing the information on: 1) the description of the derivation of the CARE-Q I items and scales; and 2) the evolved CARE/SAT. As noted the satisfaction paper should be treated as privileged communication.

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

You are welcome to use either instrument. If you decide to use one or both please let me know and provide me with an abstract of the study's findings upon completion. I would also appreciate your acknowledgement of my authorship of the instrument.

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

Sincerely,

A handwritten signature in cursive script that reads "Patricia J. Larson".

Patricia J. Larson, RN, DNSc
Assistant Professor
and Interim Chair, Oncology Program

PL/ad

Enclosures

Title: The Caring Assessment Instrument (CARE-Q) ©

Author: Patricia J. Larson, R.N., D.N.S.

Conceptualization:

Caring is viewed as an essentially and universally applicable concept underlying nursing practice and yet it is not clearly identified nor well defined. The CARE-Q was developed on the basic premise that enacted nurse caring behaviors produce a sense of "feeling cared for" in patients. Further, it is this author's belief that each and every patient has the right to expect that they will in fact feel cared for as the result of enacted nurse caring behaviors. Caring is perceived to be a part of the care dimension of nursing, permeating other dimensions such as cure and coordination.

Researcher and/or clinicians using the CARE-Q will need to make it clear in their study how they conceptualize caring. Comments relative to this author's conceptualization have been on the issues of: is this caring for or caring about? It is recognized that further work is required for the definitive conceptualization of the caring construct. The writings of Aamodt (1984); Gaut (1984); Henry (1975); Leininger (1978, 1981, 1984); and Watson (1979) provide rich resources on conceptualization of caring as it relates to nursing.

Development and Refinement of the CARE-Q:

The CARE-Q was developed for use with the Q methodology for the specific purpose of identifying the nurse caring behaviors that are perceived as important in making patients feel cared for.

The development of the instrument required two major phases. Phase I focused on the identification of the nurse caring behaviors. This was accomplished through two preliminary studies; one with nurses and another with patients. Both studies focused on nurse behaviors that convey a sense of caring.

From the results of these two studies, examination of the literature on caring, and from the author's experience in nursing, 69 nurse behaviors were identified as being representative of the caring concept of nursing. These items were labeled as "nurse caring behaviors" and became the pool of items for the subsequent development of the instrument designed to measure the perceived importance that nurses and patients have of these items. Themes of caring evolved from the patient study were retained as the scale categories for the instrument.

Phase II addressed validity and reliability. The specific behaviors and evolved themes of caring, identified in the first phase, were submitted to four review processes for the final instrument development. To address validity, two panel reviews and psychometric consultations were undertaken. In an attempt to establish the reliability of the finalized items, two test-retest studies of the CARE-Q instrument has been completed.

Validity: Face and content validity of the instrument was obtained via two review panels. Doctoral students and faculty of a large western university constituted the Expert Nurse Panel. Panel members were selected because of their experience and expertise in research and nursing practice. The panel addressed: 1) classification of behavior to caring theme; 2) content validity of each behavioral statement as being representative of the caring concept of nursing; and, 3) clarity of the statement into understandable terms.

The expert nurse panel rarely had total agreement in classifying the specific behaviors to caring theme. However, the Expert Nurse Panel was in universal agreement on 60 of the 69 items as being representative of the caring concept of nursing. Their suggestions for clarity were discussed with a psychometric expert.

Utilizing both the comments of the Expert Nurse Panel members and the advice of the psychometrician, items which did not gain consensus as representing nurse caring behavior or which were ambiguous were eliminated. Items of very similar intent were combined. These changes and the item rewording resulted in 52 item statements for final review by a patient and nurse panel.

The final review process involved examination of the 52 selected items by a panel of four staff nurses and three patients (The Patient and Staff Nurse Panel). The intent of this phase of the review process was two-fold: to address content validity by asking if each item expressed a nurse caring behavior and, secondly, to increase the reliability of the items by making them understandable to those actually involved in enacting and receiving nurse caring. Review by this panel resulted in two item statements being deleted.

Researchers and clinicians interested in construct validity are referred to Ford's (1981) work on nurse professionals' perceptions of caring and Brown's (1982) study of medical-surgical patients' indicators of care. The studies reported on in the section: Utilization of the CARE-Q, provide additional indicators of validity and reliability. The two populations it has been used with are quite consistent in their respective ranking of the CARE-Q items. Nurses who interact with oncology patients ranked the CARE-Q from one perspective (Larson, 1981, 1984); oncology patients ranked the items from an almost opposite perspective (Larson, 1981; Bork, Erath, Fargo and Kendall, 1983). Researchers, currently engaged in studies with nurses and/or patients utilizing the CARE-Q, have indicated that their preliminary data supports the consistency of this divergent perception of the ranked importance of the CARE-Q items. The data from these studies provide support that the nurse caring behavioral items of the CARE-Q have tapped the domain of caring as it relates to nursing practice.

The Final Instrument: The Caring Assessment Instrument (CARE-Q):

The resulting 50 nurse caring behavioral items and the six evolved caring themes became the item statements and scales of the instrument designed to assess and evaluate the caring behaviors of nurses. The name given to the instrument is the Caring Assessment Instrument (CARE-Q). The specified intent of the instrument is to measure, by ranked importance, the differences and similarities of perceptions that nurses and patients have of the 50 identified nurse caring behaviors. To achieve this measurement, the format of the instrument was designed to accommodate the ranking of the 50 behaviors from most important to least important by hospitalized patients and nurses. It is designed for use by both nurses and patients. Appendix A contains the CARE-Q instrument items and scales.

Procedures: The CARE-Q instrument was specifically designed for use with Q methodology to gain perceptions, by ranked order, of important nurse caring behaviors. The Q methodology was selected because of its ability to: 1) gain a diversity of individual perceptions in an objective manner; 2) aid in the identification of the most and least important items of a scale by the use of a forced-choice quasi-normal distribution; 3) be interesting and stimulating to subjects doing the sorting; and 4) evolve hypothesis/evolve a "new" theory (Green & Stone, 1973; Kerlinger, 1974; Stephenson, 1953). The forced-choice

distribution requires participants to select a predetermined number of items for each of the most important to least important categories. To complete the study a participant sorts the 50 CARE-Q cards (examples of the CARE-Q cards are found in Appendix B), into 7 different packets. The packets represent the range of most important to not important. To ensure that the most and least important behaviors were identified, they are instructed to sort out only one (1) most important; four (4) fairly important; and (10) ten somewhat important behaviors; for the twenty (20) which are neither important or unimportant, there is a similar requirement for sorting on the unimportant end of the continuum. Appendix C is representative of the CARE-Q packet format and directions for completing the sort. Pertinent demographic data on each subject is also obtained.

Each participant's item CARE-Q is numerically coded for statistical analysis. The one most important item is coded as a seven (7). The four next most important items are coded as six (6) and the ten items identified as being also important were coded as five (5). The twenty middle items were coded four (4). The ten items perceived as being less important were coded as three (3). The four items identified as being next to least important were coded as two (2) and the least important item was coded as one (1). This coding allows for derivation of the mean score of each item. The most important items are identified by a high mean score ranking; the least important items receive a lower.

Reliability: To address stability of the CARE-Q two test-retest studies have been undertaken. The first was with nine undergraduate students with at least 2½ years clinical experience. Comparison of the first sorting of the CARE-Q (Test 1) with the second sorting of the CARE-Q (Test 2) of these nursing students (N=9) revealed a perfect correlation between Test 1 and Test 2 ($r=1.0$) on the items selected as most important and least important. Beyond these two items there was little similarity in the sorting on Test 1 compared to Test 2 of the other 48 CARE-Q items by these subjects.

A second recently completed test-retest CARE-Q study with 82 registered nurse members of a national nursing specialty group revealed the item ranking consistency of the CARE-Q items ranked as most important (the top 5) to be 79.1% Test I to Test II. For the least important ranked items (the bottom 5) the consisting ratio was 63.4% (Larson, 1984).

Utilization of the CARE-Q:

The CARE-Q has been used to gain nurses' and patients' perceptions of important nurse caring behaviors. In a study contrasting hospitalized oncology patients (N=57) to professional nurses (N=57), who interact with oncology patients, revealed that these oncology patients and nurses had significantly different perceptions of the importance of nineteen of the 50 CARE-Q (15 at $P .01$; 4 at $P .05$) (Larson, 1981). A small study with 15 radiation oncology patients, recently discharged from the hospital, found that the radiation patients were similar to the hospitalized patients in their ranking of the CARE-Q items (Bork, Erath, Fargo & Kendall, 1983). A study using randomly selected nurses (N=115) belonging to a national oncology nursing organization generated CARE-Q results similar to the 57 nurses participating in the contrast of perception studies (Larson, 1984). Research utilizing the CARE-Q with population other than oncology patients is proposed. Currently, a study with arthritics with recent joint replacements is underway. At present manuscripts based on my 1981 study are being prepared for publication. Oncology Patients' Perceptions of Important Nurse Caring Behaviors has been accepted for publication in the Oncology Nursing Forum.

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CARE-Q Item #38

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

3" x 5" cards

CARE-Q Item #8

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

0919 → for use in computer program CARE-Q Item Identification

(number were derived so that they hopefully wouldn't interfere in sorted order)

MOST IMPORTANT

3145

1

Library Card Pocket

(you'll need 7... refer to Appendix C for numbering and statements)

The CARE-Q Items and Scales

Subscales	Item
<u>ACCESSIBLE</u>	<ol style="list-style-type: none"> 1. Frequently approaches the patient first, e.g., offering such things as pain medication, back rub, etc. 2. Volunteers to do "little" things for the patient, e.g., brings a cup of coffee, paper, etc. 3. Gives the patient's treatments and medications on time. 4. Checks on the patient frequently. 5. Gives a quick response to the patient's call. 6. Encourages the patient to call if he/she has problems.
<u>EXPLAINS AND FACILITATES</u>	<ol style="list-style-type: none"> 7. Tells the patient of support systems available, such as self-help groups or patients with similar disease. 8. Helps the patient not feel dumb-by giving him/her adequate information. 9. Tells the patient, in understandable language, what is important to know about his/her disease and treatment. 10. Teaches the patient how to care for himself/herself whenever possible. 11. Suggests questions for the patient to ask her/his doctor. 12. Is honest with the patient about his medical condition.
<u>COMFORTS</u>	<ol style="list-style-type: none"> 13. Provides basic comfort measures, such as appropriate lighting, control of noise, adequate blankets, etc. 14. Provides the patient encouragement by identifying positive elements related to the patient's condition and treatment. 15. Is patient even with "difficult" patients. 16. Is cheerful. 17. Sits down with the patient.

(Table 1 continued)

Subscales	Item
	18. Touches the patient when he/she needs comforting.
	19. Listens to the patient.
	20. Talks to the patient.
	21. Involves the patient's family or significant others in their care.
<u>ANTICIPATES</u>	
	22. Realizes that the nights are frequently the most difficult time for the patient.
	23. Anticipates the patient's and her/his family's shock over her/his diagnosis and plans opportunities for them, individually or as a group, to talk about it.
	24. Knows when the patient has 'had enough' and acts accordingly, e.g., rearranges an examination, screens visitors, insures privacy.
	25. Is perceptive of the patient's needs and plans and acts accordingly, e.g., gives anti-nausea medication when patient is receiving medication which will probably induce nausea.
	26. Anticipates that the 'first times' are the hardest and pays special attention to the patient during these times.
<u>TRUSTING RELATIONSHIP</u>	
	27. When with a patient, concentrates only on that one patient.
	28. Continues to be interested in the patient even though a crisis or critical phase has passed.
	29. Offers reasonable alternatives to the patient, such as choice of appointment times, bath times, etc.
	30. Helps the patient establish realistic goals.
	31. Checks out with the patient the best time to talk with the patient about changes in his/her condition.
	32. Checks her/his perceptions of the patient with the patient before initiating any action, e.g., if she/he (the nurse) has the feeling that the patient is upset with the treatment plan, discusses this with the patient before talking about it to the doctor.

(Table 1 continued)

Subscales	Item
	33. Helps the patient clarify his thinking in regard to his/her disease and treatments.
	34. Realizes that the patient knows himself the best and whenever possible includes the patient in planning and management of his/her care.
	35. Encourages the patient to ask her/him any questions he/she might have.
	36. Puts the patient first, no matter what else happens.
	37. Is pleasant and friendly to the patient's family and significant others.
	38. Allows the patient to express his feelings about his/her disease and treatment fully, and treats the information confidentially.
	39. Asks the patient what name he/she prefers to be called.
	40. Has a consistent approach with the patient.
	41. Gets to know the patient as an individual person.
	42. Introduces himself/herself and tells the patient what she/he does.
MONITORS AND FOLLOWS THROUGH	
	43. Is professional in appearance--wears appropriate identifiable clothing and identification.
	44. Makes sure that professional appointment scheduling e.g., x-ray, special procedures, etc. are realistic to the patient's condition and situation.
	45. Is well organized.
	46. Knows how to give shots, I.V.s, etc. and how to manage the equipment like I.V.'s, suction machines, etc.
	47. Is calm.
	48. Gives good physical care to the patient.
	49. Makes sure others know how to care for the patient.
	50. Knows when to call the doctor.

APPENDIX F
Instruction Sheet

DIRECTIONS

FOR CARING ASSESSMENT REPORT Evaluation Q-SORT (CARE-Q)

To participate in the study you will be required to sort 50 cards containing statements about nurse caring behaviors, ranking them from most important to least important. Individual responses will be kept confidential and every effort will be made to protect your anonymity.

The Caring Assessment Report Evaluation Q-SORT (CARE-Q) packet contains seven pockets, each labeled with a number (1, 4, 10, 20, 10, 41). Included in the packet are a deck of 50 cards, each with a different caring nurse behavior typed on it.

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

It is essential that only the designated number of cards be placed in each pocket, with the numbers (1, 4, 10, 20, etc.) on the pocket indicating the number of cards which can be placed in each pocket. When you have completed the sorting, please count the number of cards in each pocket.

2. Answer the questions on the Demographic Data Sheet and sign the consent form.
3. Place the seven pockets containing the sorted cards, the Demographic Data Sheet, and signed consent form into the enclosed addressed envelope and return via the hospital mail system (PONY).

At anytime you have a question about using the tool, please call Deanna Yamamoto, RN, at 299-5322.

Thank you so much for your help.

APPENDIX G
Follow-Up Letter

Appendix G
Follow-Up Letter

Dear: _____

Just a reminder to ask you to return the demographic data sheet, signed consent form, and the CARE-Q instrument (50 cards and 7 pockets) for the Nursing Caring Study as soon as possible. If you have already sent them, disregard this reminder and thank you for your participation in this research project.

Sincerely,

Deanna Yamamoto, R.N.
Graduate Student
San Jose State University